



**DEPARTMENT
of HEALTH
and HUMAN
SERVICES**

Fiscal Year

2006

Centers for Disease Control
and Prevention

*Justification of
Estimates for
Appropriations Committee*

TABLE OF CONTENTS

MESSAGE FROM THE DIRECTOR	4
ORGANIZATIONAL CHART.....	5
PERFORMANCE BUDGET OVERVIEW	7
<i>Statement of Mission and Discussion of Strategic Goals.....</i>	8
<i>Overview of Performance</i>	10
<i>Overview of Budget Request</i>	17
<i>Program Assessment Rating Tool (PART) Summary Table.....</i>	19
EXHIBITS	21
Exhibit E-1. Appropriations Language.....	22
Exhibit E-2. Appropriations Language Analysis	24
Exhibit F-1. Amounts Available for Obligation	26
Exhibit G. Summary of Changes.....	27
Exhibit H. Budget Authority by Activity (All Purpose Table).....	28
Exhibit H-1. Supplemental Budget Authority by Activity (Supplemental All Purpose Table).....	29
Exhibit I. Budget Authority by Object.....	30
Exhibit J. Salaries and Expenses.....	31
Exhibit K. Significant Items in Committee Reports	32
<i>House</i>	32
<i>Senate</i>	51
<i>Conference</i>	69
Exhibit L. Authorizing Legislation	71
Exhibit M. Appropriations History Table	75
NARRATIVE JUSTIFICATIONS (EXHIBITS N, O)	77
Infectious Diseases.....	78
<i>Infectious Diseases Control.....</i>	79
Functional Table	87
<i>HIV/AIDS, STD, and TB Prevention.....</i>	91
Functional Table	97
<i>Immunization</i>	101
Functional Table	110
Health Promotion	111
<i>Chronic Disease Prevention, Health Promotion, and Genomics.....</i>	112
Functional Table	131
<i>Birth Defects, Developmental Disabilities, Disability and Health.....</i>	133
Functional Table	139
Health Information and Service.....	140

<i>Health Statistics</i>	141
Functional Table	146
<i>Public Health Informatics</i>	147
Functional Table	153
<i>Health Marketing</i>	154
Environmental Health and Injury	165
<i>Environmental Health</i>	166
Functional Table	172
<i>Injury Prevention and Control</i>	173
Functional Table	177
Occupational Safety and Health	178
Functional Table	182
Global Health	186
Functional Table	194
Public Health Research.....	195
Functional Table	196
Public Health Improvement and Leadership.....	197
Functional Table	201
Preventive Health and Health Services Block Grant	203
Buildings and Facilities.....	205
Business Services Support	211
Terrorism.....	215
Functional Table	222
Influenza Reprogramming and Transfer.....	223
Reimbursements and Trust Funds	224
Agency for Toxic Substances and Disease Registry (ATSDR)	227
SUPPORTING INFORMATION.....	229
Exhibit P. State and Formula Grant Program Tables	230
Exhibit Q. Detail of Full-Time Equivalents (FTEs)	234
Exhibit R. Detail of Positions	235
Exhibit S. New Positions Requested	236
Exhibit T. Budget and Performance Crosswalk	237
Exhibit U. Detail of Performance Analysis	238
Exhibit V. Summary of Full Cost.....	317
Exhibit W. Changes and Improvements Over Previous Year	322
Exhibit X. Links to HHS and CDC Strategic Plans	324
Exhibit Y. Partnerships and Coordination.....	327
Exhibit Z. Data Verification and Validation	335
Exhibit AA. Performance Measurement Linkages	346

Exhibit BB. FY 2004-2005 One-Page PART Summaries	348
Exhibit CC. FY 2004-2005 PART Recommendations	354
Exhibit DD. Summary of Measures	364
Research Coordination Council (RCC)	365
Mechanism Table – Budget Activity	366
Crosswalk – Funding by Program and Organization (2004)	368
Crosswalk – Funding by Program and Organization (2005)	369
Crosswalk – Funding by Program and Organization (2006)	370
PRESIDENT’S MANAGEMENT AGENDA.....	371

MESSAGE FROM THE DIRECTOR

Imagine a world where infants are born healthy and cared for so they can arrive at school safe, well-nourished, and ready to learn. A world in which teenagers have the information, motivation, and hope they need to make healthy choices about their lifestyles and behaviors. A world in which adults enjoy active and productive lives in safe communities where they can remain independent and engaged with family and friends throughout their senior years. This is the vision of the Centers for Disease Control and Prevention (CDC)—healthy people living in a safe and healthy world.

CDC's Fiscal Year (FY) 2006 Congressional Justification reflects this vision. It provides evidence in support of CDC to continue enhancing our capacity to face major public health challenges both at home and abroad. It also reflects CDC's two overarching domestic goals:

1. All people, especially those at higher risk due to health disparities, will achieve their optimal lifespan with the best possible quality of health in every stage of life.
2. People in all communities will be protected from infectious, occupational, environmental, and terrorist threats.

CDC has been involved in a two-year transformation to better meet these goals in a smaller and rapidly changing world. The framework for this change is our "Futures Initiative" that is shaping CDC and serving as a catalyst for innovation in health, ultimately impacting the health of American people and, indeed, people worldwide. The transformation CDC is undergoing is also reflected in the FY 2006 budget. This new budget structure is more transparent, separating program support costs from program costs, and increasing our accountability to our customers and decision-makers.

Consistent with the Secretary's policy guidance, this budget request continues to support the President's and Secretary's priority initiatives and reflects the goals and objectives in the Department of Health and Human Services FY 2004–2009 Strategic Plan. In addition, the PART process continues to be a critical tool to evaluate program effectiveness and develop budget and legislative strategies.

This justification includes the FY 2006 Annual Performance Plan and FY 2004 Annual Performance Report as required by the Government Performance and Results Act of 1993 (GPRA). It directly links the budget discussion with program performance metrics. Comprehensive performance measurement and reporting at CDC in 15 major areas provides results-oriented information that tracks CDC's progress toward achieving its two strategic goals. Additionally, we are proud to report increased efficiencies and effectiveness in agency management, allowing us to dedicate more resources to frontline public health.

CDC's implementation of performance management has created a consistent framework for linking agency-wide goals with program priorities and resources. It has provided a shared vision of what needs to be accomplished with our partners, a consistent and effective way to measure our achievements, and a means to strive for continued and demonstrable improvement in public health. This FY 2006 budget request reflects our successes, our vision, and our commitment to ensure that we protect the health of all Americans, both now and in the future.

Sincerely,

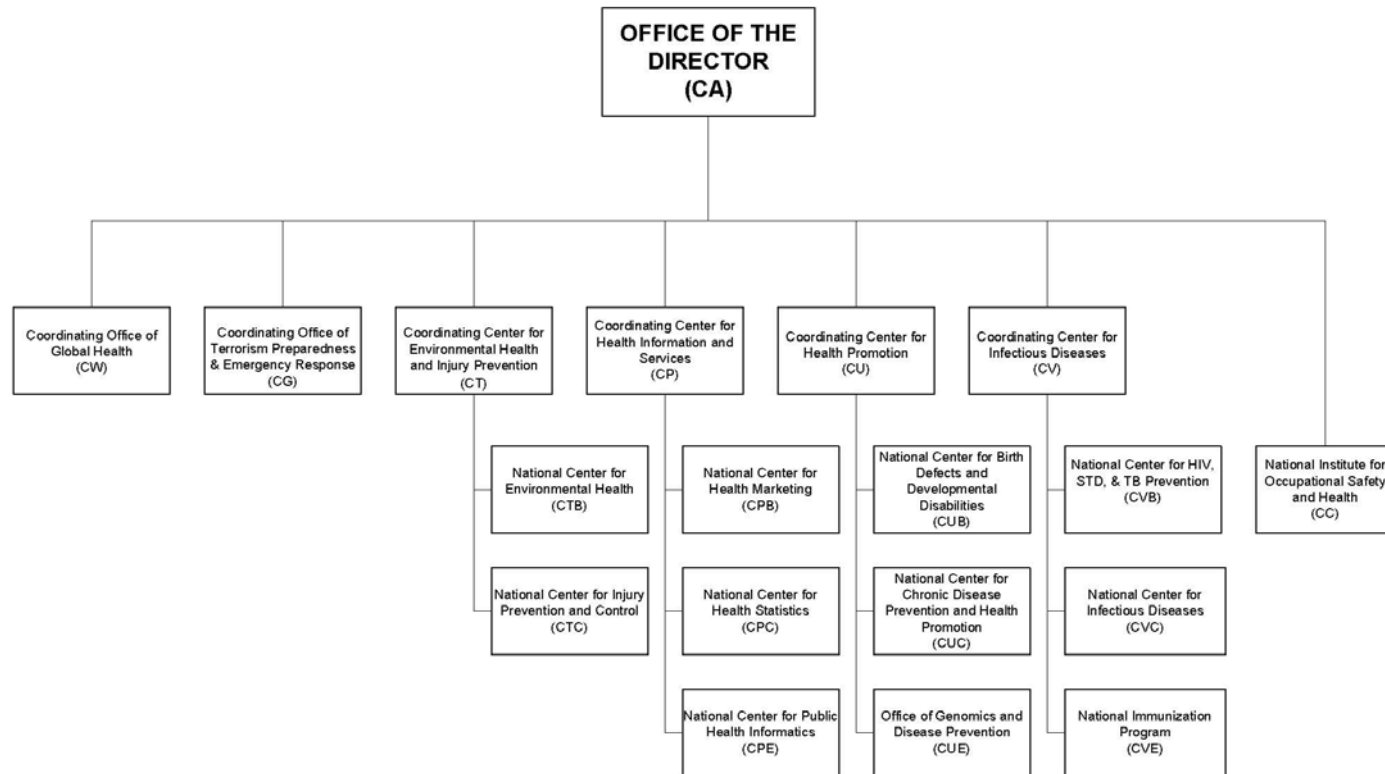
A handwritten signature in black ink that reads "Julie Louise Gerberding". The signature is written in a cursive, flowing style.

Julie Louise Gerberding, M.D., M.P.H.
 Director, Centers for Disease Control and Prevention
 Administrator, Agency for Toxic Substances and Disease Registry

ORGANIZATIONAL CHART

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

Draft Proposal - December 2004



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PERFORMANCE BUDGET OVERVIEW

STATEMENT OF MISSION AND DISCUSSION OF STRATEGIC GOALS

STATEMENT OF MISSION

There's a lot more to CDC than what makes the nightly news. We protect the health and safety of Americans and people around the globe – not just from headline-making diseases like SARS and West Nile virus, but from countless other diseases and health threats. Every day, CDC's dedicated team works around the clock and the globe to protect Americans from both naturally occurring and deliberate threats at home and abroad.

Health is more than just the absence of threats of disease and disability. It includes people's well-being, productivity, and satisfaction from birth through their senior years. Risks to health come in various forms, and CDC works with its sister agencies at HHS and its public health partners to help customers and communities protect health across the board: from environmental exposures to infectious diseases to injuries to chronic diseases.

CDC's Mission

To promote health and quality of life by preventing and controlling disease, injury, and disability.

DISCUSSION OF STRATEGIC GOALS

Beginning in FY 2003, CDC engaged in a major strategic development initiative called the "Futures Initiative." This initiative bolsters CDC's effectiveness by strengthening our capabilities in an ever-smaller and more connected world requiring globalization, connectivity, and speed. This evolution is enhancing CDC's core values of accountability, respect, and integrity while developing a more efficient, effective, and interconnected organization that responds to the needs of our customers – the American public. CDC's mission to protect public health rests on two overarching strategic goals:

- **Health promotion and prevention of disease, injury, and disability:** All people, especially those at higher risk due to health disparities, will achieve their optimal lifespan with the best possible quality of health in every stage of life
- **Preparedness:** People in all communities will be protected from infectious, occupational, environmental, and terrorist threats

As the foundation for achieving these goals, CDC is developing a set of health protection goals based on five life stages (infancy, childhood, adolescence, adulthood, and older adulthood). CDC is also establishing key performance indicators to measure progress toward meeting these goals. To address its cross-cutting preparedness activities, CDC is also developing specific goals that will span the life stages. These goals will set the direction for CDC in future years and will assist in decision-making regarding resource allocation, research agenda-setting, and recruitment and retention strategies. CDC remains committed to supporting its Healthy People 2010, Program Assessment Rating Tool (PART) and Government Performance and Results Act (GPRA) goals, which will play a role in the process of developing and tracking these new goals. By implementing recommendations from the Futures Initiative and proven business processes improvements, CDC will achieve greater positive impacts on public health.

At CDC, three core values are central to our work

ACCOUNTABILITY – As diligent stewards of public trust and public funds, we act decisively and compassionately in service to the people's health. We ensure that our research and our services are based on sound science and meet real public needs to achieve our public health goals.

RESPECT – We respect and understand our interdependence with all people both inside the agency and throughout the world treating them and their contributions with dignity and valuing individual and cultural diversity. We are committed to achieving a diverse workforce at all levels of the organization.

INTEGRITY – We are honest and ethical in all we do. We will do what we say. We prize scientific integrity and professional excellence.

CDC's mission, focus, and overarching strategic goals are complementary to the HHS Strategic Plan. In particular, CDC's FY 2006 budget request supports the following five HHS goals:

- Goal 1: Reduce the major threats to the health and well-being of Americans.
- Goal 2: Enhance the ability of the nation's health care system to effectively respond to bioterrorism and other public health challenges.
- Goal 4: Enhance the capacity and productivity of the nation's health science research enterprise.
- Goal 5: Improve the quality of health care services.
- Goal 8: Achieve excellence in management practices.

For additional information on the breakout of CDC's budget by HHS strategic goal, please refer to the Budget by Strategic Goal Table in the FY 2006 HHS Annual Plan.

OVERVIEW OF PERFORMANCE

CDC'S INCREASING IMPACT AT HOME AND ABROAD

PEOPLE IN ALL COMMUNITIES PROTECTED FROM PUBLIC HEALTH THREATS

Tsunami Response in South Asia – CDC has been playing a major role in the U.S. Government response to the December 2004 Indian Ocean tsunami. Immediately after the event, personnel assigned to South Asia (principally Thailand and India) traveled to affected locations to support relief efforts, conduct health needs assessments and disease monitoring, and assist in management of victims' remains. Through activation of the Director's Emergency Operations Center, CDC has deployed personnel to Indonesia, Sri Lanka, and Thailand to support the World Health Organization, UNICEF, and combined support function activities in health care needs assessment, disease monitoring, and program implementation, especially in the area of diarrheal disease, malaria control, immunization, nutrition, injuries, mental health support, and environmental and occupational health.

Hurricane Relief Efforts Assist Southeastern States – CDC played a key role in leading the public health response to natural disasters such as the series of hurricanes that struck the southeastern United States in August and September 2004. During the unprecedented hurricane response, CDC staff assisted state and local health departments in affected areas in establishing active surveillance systems for injuries, deaths, and illnesses related to the hurricanes. CDC subject matter experts developed educational materials for posting on CDC's Web site as well as hard-copy pamphlets in affected areas. This included materials on hurricane preparedness, preventing carbon monoxide poisoning, and food and water safety. Teams of epidemiologists traveled to affected areas and conducted surveys to assess environmental and medical needs as well as conditions in affected areas. We provided expert advice on safely sheltering storm refugees with special health needs, making sure infectious diseases weren't spread person-to-person. CDC assessed the need for mosquito control programs in hurricane-damaged areas, and environmental health specialists worked with local health department staff to ensure that water and food supplies were safe.

BioSense Initiative – CDC's BioSense initiative connects multiple disparate data sources into a fully functioning, real-time surveillance system, thus informing federal, state, and local health officials of the first signs of a public health emergency or bioterrorist attack. BioSense has concentrated on health care and health-related data such as diagnosis, procedures, and laboratory test orders and data from other federal agencies such as Department of Defense and Department of Veterans Affairs, who have partnered in this effort. Additionally, information is shared with the Department of Homeland Security, where it is integrated with other sectors (e.g. food, animal, environmental) for maximum ability to detect and characterize an event more quickly. BioSense receives daily data feeds from an initial set of data providers, and to date has received and processed over 159 million records; the BioSense application has been made available to 34 city jurisdictions and all 50 states through the enrollment of BioSense administrators and standard users and currently supports over 290 users in all states and major metropolitan areas; CDC established the Biointelligence Center to monitor incoming data from data providers; laboratory test orders and results from a national clinical laboratory performing over 300,000 tests daily were incorporated into the analytical output of the BioSense application for evaluation (to date, more 132 million clinical lab records have been received and processed); and specific monitoring capabilities for nationally significant events such as the G-8 Summit and the Democratic and Republican National Conventions were developed and implemented.

Getting the Word Out to the Public About Emergency Response – A key part of emergency response is to assure that CDC and its partners can comprehensively, efficiently, and rapidly respond to communication needs associated with terrorism and other national emergencies. To this end, the CDC Emergency Communications System (ECS) coordinates, manages, and disseminates communication materials addressing emergency situations. As part of this ongoing activity, the ECS fosters partnerships and creates channels to effectively disseminate critical emergency communication to specific audiences. In FY 2004, ECS ensured that CDC information related to key health crisis situations in 2004 – most notably, the U.S. flu vaccine shortage and the December 2004 earthquake and tsunami – was accurate, internally consistent, timely, and coordinated with CDC partners responding to these events.

(Reference Exhibit U/Detail of Performance Analysis for Terrorism: Goal 2, Performance Measure 9.)

Responding to Foodborne Public Health Threats – In FY 2004, CDC investigated outbreaks of hepatitis A in Tennessee, Georgia, North Carolina, and Pennsylvania involving over 1000 cases and at least three fatalities. The source of these outbreaks was identified as green onions grown on several different farms in Mexico. The investigation's findings resulted in an import ban by the FDA on green onions from the implicated farms.

(Reference Exhibit U/Detail of Performance Analysis for Infectious Diseases Control: Goal 3, Performance Measures 1, 2 and 3.)

Eliminating Residential Fire Deaths – Since 1998, CDC has funded smoke alarm installation and fire safety education programs in high-risk communities—those with fire death rates higher than state and national averages and median household incomes below the poverty level. A survey of homes participating in CDC-funded smoke alarm installation and fire safety education programs found that 663 lives have been saved to date. Program staff have canvassed almost 320,000 homes and installed more than 231,000 long-lasting smoke alarms in high-risk homes, targeting households with children ages five years and younger and adults ages 65 years and older. Fire safety messages have reached millions of people as a result of these programs.

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

Increasing Immunization Rates – Declining Vaccine-Preventable Diseases - The nation's childhood immunization coverage rates are at record high levels for every vaccine and for all the vaccination series measured. As childhood immunization coverage rates increase, cases of vaccine preventable diseases decline significantly. For example, during the 1990s, approximately 11,000 hospitalizations and 100 deaths occurred each year due to varicella. CDC has made great progress in educating health care providers and the public about the benefits of varicella vaccine. Coverage for varicella vaccine reached 85 percent in 2003 as opposed to only 43 percent in 1998. As a result, annual deaths have decreased to two in 2003. Overall, seven childhood diseases have been reduced by 99% or more due to vaccination.

(Reference Exhibit U/Detail of Performance Analysis for Immunization: Goal 1, Performance Measures 1, 2 and 3; Goal 2, Performance Measure 2.)

Rapid Response to 2004-2005 Influenza Season Vaccine Supply Shortage – In October, 2004, CDC was notified by Chiron Corporation that none of its influenza vaccine would be available for distribution in the U.S. for the 2004-2005 influenza season. This action reduced by approximately one-half the supply of inactivated influenza vaccine expected to be available this season. CDC, in collaboration with immunization programs nationwide, allocated available influenza vaccine to state health departments, which helped ensure the doses reached those people at highest risk for complications from influenza. CDC worked closely with the remaining manufacturer of inactivated flu vaccine, sanofi pasteur, and the vaccine distributors to design a vaccine ordering and distribution system through CDC's Secure Data Network. The Network allowed immunization programs to view vaccine doses already shipped and the distribution of priority populations by county in order to best direct vaccine as needed to public and private providers and health care facilities.

(Reference Exhibit U/Detail of Performance Analysis for Immunization: Goal 3, Performance Measures 1 and 2.)

Behavioral Risk Factor Surveillance System (BRFSS) Monitors Flu Vaccine Shortage – Significant reductions in the amount of available inactivated influenza vaccine for the 2004-2005 flu season created an urgent situation for state and local health officials and CDC. As part of CDC's response to the flu vaccine shortage, the BRFSS was quickly modified to incorporate questions relating to the shortage. State health departments and CDC are using the BRFSS to monitor the current situation on a state-by-state basis throughout the flu vaccination season. States are submitting data on a weekly basis for data analysis by a combined BRFSS and National Immunization Program analysis team. As a result, ongoing national flu coverage estimates for children and people in recommended priority groups have been available to state and federal officials. Using the BRFSS to monitor the flu vaccine shortage will continue to assist state and federal officials in responding to the current health needs of the public and with future planning.

CDC Works with Partners to Improve Global Preparedness and Response Capabilities for Influenza – Concerns over the past influenza seasons that avian influenza (H5N1) could become the next influenza pandemic led to a variety of efforts by CDC and its international partners to plan for and address threats of increased influenza activity worldwide. In February 2004, CDC issued recommendations for enhanced domestic surveillance of avian influenza A (H5N1). Following the reports of human deaths from H5N1 in Vietnam in August, CDC issued a follow-up Health Alert Network (HAN) message reiterating criteria for domestic surveillance, diagnostic evaluation, and infection control precautions for avian influenza A (H5N1). The HAN also detailed laboratory testing procedures for H5N1. CDC worked collaboratively with the World Health Organization to conduct investigations of H5N1 in Vietnam and to provide laboratory diagnostic and training assistance and has implemented an initiative to improve influenza surveillance in Asia. Additionally, CDC has engaged in training efforts both with public health practitioners in the U.S. and abroad to improve surveillance and response capacities at local levels.

(Reference Exhibit U/Detail of Performance Analysis for Infectious Diseases: Goal 2, Performance Measures 1 and 2.)

West Nile Virus Epidemic Response in the U.S. – West Nile virus (WNV) is now a permanent part of America's infectious disease landscape. Since the original introduction of the exotic arthropod-borne virus (arbovirus) WNV in the U.S. in 1999, the federal and state public health response to this epidemic continues to evolve. As of January 11, 2005, 2,470 human cases of WNV in the U.S. were reported to CDC for 2004, and a total of 16,637 human cases have been reported since 1999. Cases are still being reported for 2004. CDC continues to monitor, assess, and address the greatest threats of WNV in the country to control the spread of WNV throughout the U.S. With other federal, private, and commercial partners, CDC assisted in developing and implementing strategies and protocols that resulted in programs screening the entire U.S. blood supply for WNV contamination beginning in 2003; more than 2.5 million blood donations were screened for WNV each year. Since screening began, 1,016 presumptively viremic donors have been reported to CDC (including 2003 and 2004). CDC continues to work with partner agencies and organizations to identify the best approaches to use in the future to ensure the safety of the blood supply.

Foodborne Illness Prevention Strategies Showing Promising Trends – FoodNet, a network of ten sites around the U.S. that monitors nearly 42 million persons and provides the most comprehensive information available on foodborne illness, was established in 1995. FoodNet shows that infections with *E. coli* O157 have declined 42 percent since 1996, *Campylobacter* by 28 percent, and *Salmonella* by 17 percent. These encouraging results suggest prevention strategies are having some effect, but further prevention efforts are needed to meet national health goals.

(Reference Exhibit U/Detail of Performance Analysis for Infectious Diseases Control: Goal 3, Performance Measures 1 and 2.)

Advancing Polio Eradication – CDC and its international partners have made extraordinary progress toward achieving the global eradication of polio. An estimated 250,000 lives have been saved and five million cases of childhood paralysis prevented since the global polio initiative began in 1988. Cases of polio worldwide have declined from 350,000 in 1988, to 784 cases reported in 2003. Polio is confined to fewer than 20 countries now, down from 125 countries when the global eradication effort began in 1988. In 2004, polio declined by nearly 50 percent in India, Pakistan, and Afghanistan. However, vanquishing polio requires constant efforts. In 2003 and 2004, wild poliovirus spread from Nigeria to other countries in west and central Africa. Polio transmission was re-established in five countries and imported polio cases occurred in several others. An outbreak of polio in Sudan has paralyzed more than 100 children, adding to the humanitarian crisis resulting from the conflict in Darfur. The tremendous success of the last 16 years doesn't mean we can be complacent.

(Reference Exhibit U/Detail of Performance Analysis for Global Health: Goal 3, Performance Measures 1 and 2.)

Improving Prevention of Global Malaria – CDC completed and published a bednet study compendium demonstrating that in an area of high malaria transmission, bednets are an effective intervention tool reducing all-cause childhood mortality by 20 percent. This proves that bednets are as effective a public health intervention as many vaccines. CDC also collaborated with Roll Back Malaria partners on the development of the African Strategic Framework for Malaria Prevention in Pregnancy and worked in Malawi to increase national coverage of malaria prevention to exceed 80 percent.

Global AIDS Program – CDC's Global AIDS Program (GAP) is working with 25 countries in Africa, Asia, the Caribbean and Latin America to prevent HIV infection, improve treatment for people living with AIDS, and reduce mother-to-child HIV infections. Fifteen of the 25 countries in which CDC/GAP has offices are also part of the unified U.S. Government effort to implement the President's Emergency Plan for AIDS Relief (Emergency Plan). This five-year, \$15 billion initiative aims to combat the global HIV/AIDS pandemic by treating 2 million HIV-infected people, preventing 7 million new infections, and providing care to 10 million HIV-infected individuals and AIDS orphans. In FY 2003, more than 25,000 pregnant women received antiretroviral drugs (ARVs) at 2,653 CDC/GAP-supported prevention of mother-to-child transmission (PMTCT) sites, potentially averting about 2,200 infant HIV-infections. Nearly 600,000 individuals were tested at CDC/GAP-supported voluntary counseling and testing sites, and 602,774 pregnant women were tested at PMTCT sites.

(Reference Exhibit U/Detail of Performance Analysis for Global Health: Goal 1, Performance Measure 1; and Goal 2, Performance Measure 1.)

Advancing HIV Prevention: New Strategies for a Changing Epidemic – Taking advantage of new technology to offer innovative strategies and approaches to combat HIV, CDC has retooled its domestic HIV prevention programs with a new initiative, Advancing HIV Prevention (AHP). The initiative is designed to increase the number of persons who are aware of their infection, link those persons with care and prevention services, and reduce new infections in the U.S. AHP builds on current proven HIV prevention strategies and incorporates new technologies, such as rapid HIV testing. The majority of HIV infections are transmitted by people who have not yet been diagnosed. The initiative is reaching out to identify the estimated 180,000 to 280,000 people in the U.S. who are not aware of their status and connect them to care and treatment. Under AHP, CDC has distributed more than 530,000 rapid test kits to 194 training sites around the country and conducted more than 20 training sessions on rapid HIV testing.

(Reference Exhibit U/Detail of Performance Analysis for HIV/AIDS, STD and TB Prevention: Goal 3, Performance Measures 1 – 5.)

Tuberculosis (TB) Cases Decline for an Eleventh Consecutive Year – TB case rates nationwide are at an all-time low following the 11th consecutive year of decline, moving us closer to our goal of TB elimination in the U.S. CDC is using new tools in the fight against TB, such as its Tuberculosis Genotyping Program, which provides rapid TB “fingerprinting” results to TB control programs across the U.S. The program was initiated in FY 2004. Genotyping can help health officials detect outbreaks almost immediately by analyzing the “fingerprints” of individual TB strains. This early detection of TB outbreaks allows health officials to take needed control measures. For example, TB genotyping was able to link five apparently unrelated TB patients to a Kansas homeless shelter. The findings led to mandatory TB screening for clients and workers in the community’s homeless shelters.

(Reference Exhibit U/Detail of Performance Analysis for HIV/AIDS, STD and TB Prevention: Goal 11, Performance Measure 1.)

Creating a Better Trained Public Health Workforce – The Centers for Public Health Preparedness (CPHPs) are important in developing a competent public health workforce. There are 41 CPHPs in the U.S. housed in academic institutions such as Columbia University, the University of California at Berkeley, and Emory University. The centers have established a national internet resource center through the Association of Schools of Public Health (ASPH) that lists over 300 courses Centers for Public Health Preparedness focused on a specific content area, discipline, technology, or setting. These centers produce research, training and related materials to enhance national preparedness efforts.

(Reference Exhibit U/Detail of Performance Analysis for Terrorism: Goal 1, Performance Measure 16.)

Expansion of CDC’s Disease Detectives – CDC provides expert assistance, especially through its “disease detectives,” the Epidemic Intelligence Service (EIS) officers. In the last seven years 501 students have completed their rotational requirements. In FY 2004, the 167 current EIS officers responded to 90 outbreaks in a variety of locations, including 17 international response efforts. Requests for assistance have involved primarily infectious disease problems but also include environmental health, injuries, maternal and child health, and other problems. Additionally, all EIS officers now receive training in terrorism preparedness and emergency response.

(Reference Exhibit U/Detail of Performance Analysis for Public Health Workforce Development: Goal 1, Performance Measure 1; and Terrorism: Goal 1, Performance Measure 3).

Career Epidemiology Field Officer Program Underway - The Career Epidemiology Field Officer Program was established after the attacks on the World Trade Center and Pentagon, the anthrax investigation, and the WNV epidemic to address the need for trained epidemiologists at the state and local levels. Currently, 19 Career Epidemiology Field Officers are placed in state and local health agencies to provide epidemiological expertise to state terrorism and emergency response planning and policy and to provide leadership, training, planning and technical support for building local epidemiological capacity.

(Reference Exhibit U/Detail of Performance Analysis for Terrorism: Goal 1, Performance Measure 3).

Preparing for New Cases of SARS – As new cases of laboratory-associated SARS erupted in the spring of 2004, CDC developed a satellite broadcast to alert laboratorians and researchers worldwide about precautions and preventive measures in working with the SARS virus and other biosafety level 3 agents. As of November 2004, these broadcasts have been viewed by more than 4,700 laboratorians and researchers.

Improving Laboratory Response Capacity – CDC has increased the number of Laboratory Response Network (LRN) labs to 139, up from 91 in 2001. These labs are now located in all 50 states with several installations also located outside the U.S. Currently, 96 percent of these labs can confirm the presence of anthrax, 94 percent can confirm the presence of tularemia, and 63 percent can perform presumptive screening for smallpox. In addition, CDC has trained more than 8,800 clinical laboratorians on detection, diagnostics, and reporting of public health emergencies.

(Reference Exhibit U/Detail of Performance Analysis for Terrorism: Goal 1, Performance Measure 7 – 11).

Syphilis Declines in Women and Infants – The number of cases of congenital syphilis —occurring among infants under 1 year of age — and of primary and secondary syphilis among women has declined since CDC launched its National Plan to Eliminate Syphilis in 1999. Since 1998, the number of cases of congenital syphilis has fallen about 51 percent, with 413 cases in 2003. During that time period, primary and secondary syphilis among women has declined by 61 percent, with 1,218 cases in 2003. Congenital syphilis occurs when syphilis is transmitted from a pregnant woman with syphilis to her fetus. Untreated syphilis during pregnancy can lead to stillbirth, neonatal death, or infant disorders, such as deafness, neurologic impairment, and bone deformities. CDC’s Syphilis Elimination program partners with other public health agencies, the private medical community, and other organizations involved in STD and HIV prevention.

(Reference Exhibit U/Detail of Performance Analysis for HIV/AIDS, STD and TB Prevention: Goal 8, Performance Measure 1; and Goal 10, Performance Measures 1b and 2.)

ALL PEOPLE WILL ACHIEVE OPTIMAL LIFESPAN AND BEST QUALITY OF HEALTH IN EACH LIFESTAGE

CDC Boosts Extramural Research to Protect Americans' Health – In FY 2004, CDC committed new funding to support the innovative Health Protection Research Initiative aimed at further promoting and protecting the health of Americans, with an immediate focus on producing a body of evidence that will help employers make better choices in wellness programs. The first element of this new research initiative targets projects that will provide employers with the evidence they need to promote the health of their workforce. Effective interventions at the workplace in the form of wellness programs can greatly assist employees in smoking cessation, physical fitness, weight reduction, and other health risk factors.

CDC expects projects designed to affect health in the workplace will have a positive economic and health impact. For example, with more than 60 percent of U.S. adults being overweight or obese, estimated direct and indirect costs of diabetes were nearly \$132 billion in 2002, and estimated annual U.S. medical expenditures attributed to obesity are \$93 billion in 2002. The economic cost of obesity to business, including health, life and disability insurance and paid sick leave by private sector firms was estimated to be at least \$15.4 billion in 2002.

In FY 2004, approximately \$22 million was awarded for this initiative including 31 investigator-initiated grants to evaluate and improve a variety of health promotion strategies in the workplace setting; 21 grants to support career development experiences among current research scientists to address CDC's health protection research priorities; three institutional awards to develop or enhance training programs that offer training in health protection research; and two institutional awards for Centers of Excellence in Health Promotion Economics that will explore economic solutions to evaluating effective health promotion programs and policies and assessing their cost effectiveness.

The extramural research community responded enthusiastically to CDC's Health Protection Research Initiative, as evidenced by more than 200 applications submitted by research scientists. CDC awarded 57 grants (approximately 28 percent of applications) in FY 2004 and will increase this investment in FY 2005.

Reducing Tobacco Use – Tobacco use remains the leading preventable cause of death in America, causing approximately 440,000 deaths and costing more than \$75 billion in direct medical costs every year. The need for proactive tobacco prevention and control programs is clear. Surgeon General Richard H. Carmona released his first Surgeon General's Report on Smoking on May 27, 2004. This report comes on the 40th anniversary of the landmark Luther Terry report, the first surgeon general's report to causally link smoking with some types of cancer. The 2004 Surgeon General's Report on Smoking showed that smoking caused cancers in parts of the body (kidney, cervix, bone marrow) that have not been previously linked to smoking. The report concluded that smoking harms nearly every organ of the body, causing many diseases and reducing the health of smokers in general.

In FY 2004, CDC funded a national network of smoking cessation quitlines to provide smokers in the U.S. access to the support and latest information to help them quit. A key component of the national network of quitlines is the establishment of a single, toll-free national number – 1-800-QUIT NOW that serves as a portal, linking callers to their state's telephone cessation services.

Perhaps the most impressive accomplishment has been the decline in smoking among young people, after nearly a decade of rising smoking rates among youth. In FY 2004, a CDC study showed fewer adolescents smoke now than any time since 1991. CDC initiatives, state and local programs, and increases in cigarette retail prices have helped to drive down the percentage of high school students who smoke from 36 percent in 1997 to 22 percent in 2003—a drop of around approximately two million young people who smoke. Studies show that 80 percent of adults who smoke started smoking before age 18. Deterring youth smoking is directly correlated with reducing preventable adult deaths.

(Reference Exhibit U/Detail of Performance Analysis for Chronic Disease Prevention and Health Promotion: Goal 5, Performance Measure 1.)

Folic Acid-Preventable Birth Defects Decline Dramatically – Spina bifida and anencephaly, serious birth defects of the brain and spine, continue to decline because of folic acid food fortification and public health education efforts. Since fortification of cereal grain products was required in 1998, the rates of these defects have declined by 26 percent. CDC is now engaging in a media campaign targeting Hispanic women, as this ethnic group is at a two-fold increased risk for spina bifida and anencephaly.

(Reference Exhibit U/Detail of Performance Analysis for Birth Defects, Developmental Disabilities, Disability and Health: Goal 1, Performance Measure 2.)

Successful Coalition Building through REACH 2010 – Racial and Ethnic Approaches to Community Health (REACH) 2010 is an important cornerstone of CDC efforts to eliminate racial and ethnic disparities in health. The REACH 2010 Program is in its fourth year of implementation in 31 communities across the country. The REACH 2010 program has made significant inroads in reducing rates of cardiovascular disease, diabetes, breast cancer, HIV/AIDS while increasing rates of childhood immunizations in minority, at-risk populations. Besides the 31 communities, REACH 2010 also provides annual funding for four programs for the elderly and five American Indian and Alaskan Native Project (AI/AN) programs.

As an example of REACH 2010 in action, the University of Alabama at Birmingham works with a variety of community-based, religious, grassroots, and health care organizations to improve breast and cervical cancer screening in rural counties throughout the state. In Macon County, disparity in use of mammography screening was reduced from 15 percent in 1998 to 2 percent in 2003. In Dallas County, there was a reduction of 70 percent over this period. Also, 42 percent of women reported at the start of the program that they had not had a Pap test have now had at least one Pap test.

Reducing Work-Related Injuries, Illnesses, and Fatalities – By identifying emerging work-related injuries and illnesses, CDC helps reduce the annual incidence of work injuries, illnesses, and fatalities, in targeted sectors. After recognizing fatal falls during communication tower construction as an emergent hazard, CDC worked closely with industry and government partners to identify safe practices in this construction sector. While conducting a health hazard evaluation in a poultry processing facility, CDC researchers developed new analytic methods to identify exposure to chloramines and protect workers from the previously elusive occupational hazard. A recent extramural research partnership with a nursing home company, documented a 61 percent reduction in injury rates, and a 37 percent reduction in workers' compensation expenses related to patient lifting and transferring.

(Reference Exhibit U/Detail of Performance Analysis for Occupational Safety and Health: Goal 2, Performance Measure 1.)

CDC Publishes Most Extensive Assessment of Exposure of U.S. Population to Environmental Chemicals – CDC published the Second National Report on Human Exposure to Environmental Chemicals, the largest and most extensive assessment of the U.S. population's exposure to environmental chemicals. The publication reports exposure information for 116 environmental chemicals, including information on lead, environmental tobacco smoke (ETS), and the insecticide DDT. By the end of the 2005-2006 sampling of the U.S. population, the number of chemicals for which data is collected will increase to 180.

(Reference Exhibit U/Detail of Performance Analysis for Environmental Health: Goal 1, Performance Measure 1.)

Data Collection Results in Call to Action for Obesity/Overweight – Data collected on overweight prevalence and increased calorie consumption through the National Health and Nutrition Examination Survey (NHANES) and the Behavioral Risk Factor Surveillance System (BRFSS) illustrate the percentage of Americans at elevated risk of a variety of health problems. To address the fact that 31% of the U.S. population 18 years and older are obese and 64% are overweight or obese, CDC is working with schools, communities, and industry to combat overweight and obesity. The Secretary and the CDC Director have brought attention to the problem by discussing positive steps the public can take to exercise and eat more healthfully. Additionally, these data have led to legislative initiatives and major changes in the messages and food choices made available by the food industry. For example, several states have introduced legislation pertaining to improved labeling of foods sold in restaurants, reporting BMI of school-aged children, and restricting access or prohibiting vending machines in schools. In addition, parts of the food industry have responded by reducing or eliminating trans fats from their products, and by developing more healthful, "better for you," food and beverage options.

(Reference Exhibit U/Detail of Performance Analysis for Health Statistics: Goal 1, Performance Measure 1, Targets A and B.)

Providing Authoritative Public Health Messages and Information – This past year, CDC launched its newly redesigned Web site. Key improvements include making the site more citizen-centered including improvements in use, navigation, searching, interactivity, personalization, and enriching and expanding content in a consumer-oriented presentation. CDC has one of the most frequently visited Web sites in the government as the authoritative trusted source of public health information for health care providers, public health officials, the media, and the public. CDC's Web site attracts ten million different visitors per month on average. The SARS outbreak resulted in over 17 million different visitors in April 2003.

(Reference Exhibit U/Detail of Performance Analysis for Infectious Diseases: Efficiency Measure 1; Health Statistics: Efficiency Measure 1; Terrorism: Goal 2, Performance Measure 1.)

PERFORMANCE APPROACH

CDC's FY 2006 Congressional Justification contains 120 performance measures: 51 outcome measures, 55 output measures and 14 efficiency measures. Every year, CDC continues to refine its measures to become more outcome-oriented and efficient.

As of January 2005, CDC reported on 70 of 119 measures in its FY 2004 Performance Report. Of these reported measures for FY 2004, CDC met or exceeded 83 percent of its targets. Additionally, CDC reported on 122 of 132 measures in its FY 2003 Performance Report. Of these reported measures for FY 2003, CDC met or exceeded 86 percent of its targets. Finally, CDC reported on 175 of 178 measures in its FY 2002 Performance Report. Of these reported measures for FY 2002, CDC met or exceeded 77 percent of its targets. Measures with outstanding data will be reported as soon as results become available.

Many of CDC's performance measures and goals support CDC's two overarching domestic strategic goals, as well as Healthy People 2010, the HHS Strategic Plan, and the President's Management Agenda (PMA). Links from the performance measures to these initiatives are indicated within Exhibit U: Detail of Performance Analysis.

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

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

Please refer to the preceding "Discussion of Strategic Goals" for additional information regarding the HHS Strategic Plan.

OVERVIEW OF BUDGET REQUEST

CDC's FY 2006 budget request of \$7.5 billion represents a decrease of \$491 million below the FY 2005 Enacted level. This budget reflects the Administration's commitment to ensuring that the health of the nation and our global community is protected and enhanced by providing the nation's best public health research and programs in collaboration with our partners.

The FY 2006 request will enable CDC to maintain its excellent public health programs at FY 2005 Enacted levels while enhancing several areas to address the most pressing public health challenges facing the U.S. The FY 2006 budget request includes funding for enhancements to two existing programs at CDC: the Section 317 Immunization program and the Global Disease Detection initiative. The budget request also includes reductions in several areas, including the Youth Media Campaign, Public Health Information Network, Preventive Health and Health Services Block Grant, Buildings and Facilities, State and Local Preparedness Cooperative Agreements, and Anthrax Research Program. In total, the FY 2006 President's Budget reflects the challenges of the global environment in which we live and the opportunities for improving public health in our nation and the world.

PROGRAM INCREASES

SECTION 317 PROGRAM: INFLUENZA (+\$50 MILLION)

CDC's Immunization Grant Program (Section 317) provides vaccines for children, adolescents, and adults who present primarily at local health departments but are not eligible for the Vaccines for Children program. These populations are primarily underinsured, insured but with high deductibles, or the working poor. A variety of vaccines are purchased through the Section 317 program, but vaccine shortages during the 2004-2005 influenza season have highlighted the fragility of the influenza vaccine market and the need for its expansion and stabilization. Maintaining an abundant influenza vaccine supply is critically important for protecting the public's health and improving our preparedness for an influenza pandemic. CDC will alleviate the impact of next year's influenza season by taking aggressive steps to ensure an expanded influenza supply to protect the nation. To this end, the FY 2006 budget request includes an increase of \$30 million for CDC to enter into back-end sales guarantee contracts through the Section 317 Immunization program to ensure the production of bulk monovalent influenza vaccine. If supplies fall short, this bulk product can be turned into a finished trivalent influenza vaccine product for distribution. If supplies are sufficient, the bulk vaccine can be held until the following year's influenza season and developed into vaccines if the circulating strains remain the same. This back-end guarantee will help to expand the influenza market by adding guaranteed capacity to existing producers and perhaps serve as an enticement for additional manufacturers to enter the market. In addition, the FY 2006 budget includes an increase of \$20 million to support influenza vaccine purchase activities through Section 317.

GLOBAL DISEASE DETECTION (+\$12 MILLION)

The Global Disease Detection initiative aims to recognize infectious disease outbreaks faster, improve the ability to control and prevent outbreaks, and to detect emerging microbial threats. CDC will continue the implementation of a comprehensive system of surveillance by expanding the Emerging Infections Program (EIP) and the Field Epidemiology and Laboratory Training Program (FELTP). This network is a phased approach that requires ongoing support for existing country/regional platforms while bringing a high level of focus and attention to develop new sites. An effective network would have a strategic presence across the globe with enhanced information technology and laboratory infrastructure that would allow for the broadest possible detection and response capacities before a significant event occurs. Additional activities include the improvement of early warning systems; researching new viral strains; aiding in collaborations with multinational organizations; and increasing surveillance.

STRATEGIC NATIONAL STOCKPILE (+\$203 MILLION)

The creation of the Strategic National Stockpile (SNS) has allowed CDC to prepare for mass trauma events and respond by delivering medical supplies to any point in the U.S. within 12 hours. To ensure adequate supplies of the anti-toxins and vaccines needed for necessary readiness levels, the FY 2006 budget request includes increased funding to purchase additional countermeasures. Funding is also included in the FY 2006 budget request to support a preplanned federal mass care facility for the HHS Federal Medical Contingency Stations program, a federal-level contingency care program in the event of a mass-casualty event.

PROGRAM DECREASES

YOUTH MEDIA CAMPAIGN (-\$59 MILLION)

CDC's VERB: Its What You Do - Youth Media Campaign, was authorized for five years in FY 2001 to clearly communicate messages that will help kids develop habits that foster good health, including promoting mental health over a lifetime and address the growing problem of obesity in this country. The VERB Campaign has been a tremendous federal project since its inception in 2001. The Verb Program was not intended to be a long-term national program, and funding has resulted in many positive results, as well as an excellent example of how effective partnerships with private industry can leverage limited government funds.

PUBLIC HEALTH INFORMATION NETWORK (-\$5 MILLION)

The Public Health Information Network (PHIN) supports public health across the broad range of public health functions by ensuring electronic information systems capabilities are in place. PHIN leverages existing systems and builds upon them to link critical areas of public health and identify gaps associated with information capabilities. The FY 2006 budget request includes a decrease of \$5 million for PHIN as CDC moves from standards design to system implementation.

PREVENTIVE HEALTH AND HEALTH SERVICES BLOCK GRANT (-\$131 MILLION)

The Preventive Health and Health Services Block Grant provides 61 grantees with funding for prevention and health promotion programs. The FY 2006 budget request eliminates funding for this program. As the agency strives to improve efficiency and eliminate overlap, existing resources will be maintained in programs that address similar public health issues.

BUILDINGS AND FACILITIES (-\$240 MILLION)

Funding at \$30 million for Buildings in Facilities in FY 2006 will support repairs and improvements for existing facilities as well as completing construction of the Ft. Collins, Colorado Vector Borne Infectious Diseases Replacement Laboratory.

STATE AND LOCAL TERRORISM COOPERATIVE AGREEMENTS (-\$130 MILLION)

One source of funding for state and local health departments is provided through CDC's Cooperative Agreement on Public Health Preparedness and Emergency Response. While recognizing competing priorities and some state and local level constraints to effectively utilize grant funds, CDC proposes reducing funds for these cooperative agreements in FY 2006 by \$130 million.

ANTHRAX (-\$17 MILLION)

The anthrax research study, begun in 2001 as a result of the anthrax attacks that affected the U.S., is nearing its conclusion. The information gleaned over the course of this study will not be compromised due to its culmination, and the expected benefits will have been gained by the time of the project's completion.

ADMINISTRATIVE SAVINGS (-\$15 MILLION) AND INFORMATION TECHNOLOGY REDUCTION (-\$10 MILLION)

Funding for Business Services Support in FY 2006 includes an administrative savings of \$15 million, which CDC anticipates realizing as a result of various consolidations and the new CDC budget and organizational structure. CDC's budget request for FY 2006 also includes an information technology reduction of \$10 million, which is realized in project-specific areas across CDC's budget.

PROGRAM ASSESSMENT RATING TOOL (PART) SUMMARY TABLE

(Dollars in Millions)

PART PROGRAM	FY 2004 ACTUAL	FY 2005 APPROPRIATION	FY 2006 ESTIMATE	NARRATIVE RATING
FY 2004				
317 Immunization Program ¹	\$468.8	\$515.8	\$428.7	Adequate
Breast and Cervical Cancer	\$197.2	\$204.4	\$204.5	Adequate
Diabetes	\$60.0	\$63.5	\$63.5	Adequate
Domestic HIV/ AIDS Prevention	\$667.9	\$662.3	\$657.7	Results Not Demonstrated
Health Alert Network ²	N/A	N/A	N/A	N/A
FY 2005				
State and Local Preparedness ³	\$918.5	\$926.7	\$797.1	Results Not Demonstrated
FY 2006				
Buildings and Facilities	\$260.5	\$269.7	\$30.0	Adequate
Epidemic Services and Response ²	N/A	N/A	N/A	N/A
Occupational Safety and Health ⁴	\$277.0	\$286.0	\$285.9	Adequate
Infectious Diseases	\$221.7	\$225.6	\$224.8	Adequate
Sexually Transmitted Diseases / Tuberculosis	\$295.9	\$298.4	\$298.6	Adequate

¹ Funding levels for the 317 Immunization Program include all discretionary, domestic immunization activities. FY 2005 funding includes a reprogramming and transfer into CDC of \$36.8 million for influenza activities. FY 2006 funding reflects proposed law.

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

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

⁴ Funding levels for Occupational Safety and Health include funding received from Public Health Evaluation Transfers and the administrative and management costs related to Occupational Safety and Health Activities.

For CDC's PART programs with a "Results Not Demonstrated" rating, including Domestic HIV/AIDS Prevention and State and Local Preparedness, funding should be continued at requested levels because of the significant progress being made toward the programs' PART Recommendation Follow-up Plans. Their progress is detailed in Exhibit CC of this document. Further, both programs have been preparing for and will go through a comprehensive PART re-review during FY 2005.

PERFORMANCE BUDGET OVERVIEW
PROGRAM ASSESSMENT RATING TOOL (PART) SUMMARY TABLE

The vast majority of CDC's PART programs align to the Department's Strategic Goal #1. However, State and Local Preparedness aligns to Strategic Goal #2, as well as to the Secretary's FY 2006 budget priority related to Bioterrorism. These applicable goals and priority are detailed below.

- Goal 1: Reduce the major threats to the health and well-being of Americans.
- Goal 2: Enhance the ability of the Nation's health care system to effectively respond to Bioterrorism and other public health challenges.
- FY 2006 Budget Priority: Responding to Bioterrorism and other Public Health Emergencies: Improving our ability to protect Americans from novel pathogens, e.g., a pandemic influenza strain, and reducing the potential public health effects of an attack with weapons of mass destruction.

EXHIBITS

EXHIBIT E-1. APPROPRIATIONS LANGUAGE

EXHIBIT E-1: CENTERS FOR DISEASE CONTROL AND PREVENTION APPROPRIATION LANGUAGE

DISEASE CONTROL, RESEARCH, AND TRAINING

To carry out titles II, III, VII, XI, XV, XVII, [XIX], XXI, and XXVI of the Public Health Service Act, sections 101, 102, 103, 201, 202, 203, 301, and 501 of the Federal Mine Safety and Health Act of 1977, sections 20, 21, and 22 of the Occupational Safety and Health Act of 1970, title IV of the Immigration and Nationality Act, and section 501 of the Refugee Education Assistance Act of 1980; including purchase and insurance of official motor vehicles in foreign countries; and purchase, hire, maintenance, and operation of aircraft, [\$4,553,910,000] \$4,040,963,000, of which [\$272,000,000] \$30,000,000 shall remain available until expended for equipment, and construction and renovation of facilities[.]; of which \$30,000,000 of the amounts available for immunization activities shall remain available until expended; and of which [\$124,882,000] \$123,883,000 for international HIV/AIDS shall remain available until September 30, [2006] 2007. In addition, such sums as may be derived from authorized user fees, which shall be credited to this account: Provided, That in addition to amounts provided herein, the following amounts shall be available from amounts available under section 241 of the Public Health Service Act (1) \$12,794,000 to carry out the National Immunization Surveys; (2) \$109,021,000 to carry out the National Center for Health Statistics surveys; (3) \$24,751,000 to carry out information systems standards development and architecture and applications-based research used at local public health levels; (4) \$463,000 for Health Marketing evaluations; (5) \$31,000,000 to carry out Public Health Research; and (6) \$87,071,000 to carry out [Research Tools and Approaches] research activities within the National Occupational Research Agenda: Provided further, That none of the funds made available for injury prevention and control at the Centers for Disease Control and Prevention may be used, in whole or in part, to advocate or promote gun control: Provided further, That up to \$30,000,000 shall be made available until expended for Individual Learning Accounts for full-time equivalent employees of the Centers for Disease Control and Prevention: Provided further, That the Director may redirect the total amount made available under authority of Public Law 101-502, section 3, dated November 3, 1990, to activities the Director may so designate: Provided further, That the Congress is to be notified promptly of any such transfer: Provided further, That not to exceed \$12,500,000 may be available for making grants under section 1509 of the Public Health Service Act to not more than 15 States, tribes, or tribal organizations: Provided further, That without regard to existing statute, funds appropriated may be used to proceed, at the discretion of the Centers for Disease Control and Prevention, with property acquisition, including a long-term ground lease for construction on non-Federal land, to support the construction of a replacement laboratory in the Fort Collins, Colorado area: [Provided further, That notwithstanding any other provision of law, a single contract or related contracts for development and construction of facilities may be employed which collectively include the full

scope of the project: *Provided further*, That the solicitation and contract shall contain the clause “availability of funds” found at 48 CFR 52:232-18:] *Provided further*, That of the funds appropriated, \$10,000 is for official reception and representation expenses when specifically approved by the Director of the Centers for Disease Control and Prevention.

EXHIBIT E-1: HEALTH AND HUMAN SERVICES GENERAL PROVISIONS SECTION APPROPRIATION LANGUAGE

Section 217: Funds which are available for Individual Learning Accounts for employees of the Centers for Disease Control and Prevention (CDC) and the Agency for Toxic Substances and Disease Registry (ATSDR) may be transferred to "Disease Control, Research, and Training," to be available only for Individual Learning Accounts: Provided, That such funds may be used for any individual full-time equivalent employee while such employee is employed by either CDC or ATSDR.

EXHIBIT E-2. APPROPRIATIONS LANGUAGE ANALYSIS

EXHIBIT E-2: CENTERS FOR DISEASE CONTROL AND PREVENTION LANGUAGE ANALYSIS

LANGUAGE ANALYSIS

PURCHASE AND LANGUAGE PROVISION	EXPLANATION
<i>"...including purchase and insurance of official motor vehicles in foreign countries..."</i>	No specific authorization exists for the provision regarding insurance; however, experience of the Centers for Disease Control and Prevention (CDC) in stationing Public Health Service officials overseas and at the Mexican Border indicates that this provision is essential. Unless adequate automobile insurance is provided, Public Health Service officials could be subject to arbitrary arrest if they were involved in an accident.
<i>"...and purchase, hire, maintenance, and operation of aircraft..."</i>	CDC must maintain the ability to purchase or hire aircraft for deployment of the Strategic National Stockpile or other emergency response operations; testing of new insecticides and formulations; and for applying the insecticides when outbreaks of mosquito-borne disease, such as encephalitis, occur in populous areas where no other method can be used to control the spread of the disease.
<i>"...of which [\$272,000,000] \$30,000,000 shall remain available until expended for equipment, and construction and renovation of facilities ..."</i>	Provides specific authorization for CDC to fund the construction, maintenance, and improvement of CDC buildings and facilities.
<i>"...of which \$30,000,000 of the amounts available for immunization activities shall remain available until expended..."</i>	Increased funding in FY 2006 for immunization will allow CDC to enter into back-end guarantee contracts with manufacturers to increase the influenza vaccine supply and encourage entry of new manufacturers into the market.
<i>"...such sums as may be derived from authorized user fees, which shall be credited to this account."</i>	Provides specific authorization to allow all funds collected as user fees to be deposited to this appropriation.
<i>"...\$87,071,000 to carry out [Research Tools and Approaches] research activities within the National Occupational Research Agenda..."</i>	Allows CDC to utilize Section 317 funding to conduct all research activities related to the National Occupational Research Agenda rather than limiting use of these funds to Research Tools and Approaches.

EXHIBIT E-2: HEALTH AND HUMAN SERVICES GENERAL PROVISIONS SECTION LANGUAGE ANALYSIS

LANGUAGE ANALYSIS

PURCHASE AND LANGUAGE PROVISION	EXPLANATION
<p><i>Section 217: Funds which are available for Individual Learning Accounts for employees of the Centers for Disease Control and Prevention (CDC) and the Agency for Toxic Substances and Disease Registry (ATSDR) may be transferred to "Disease Control, Research, and Training," to be available only for Individual Learning Accounts: Provided, That such funds may be used for any individual full-time equivalent employee while such employee is employed by either CDC or ATSDR.</i></p>	<p>CDC's appropriation includes language to provide funding for Individual Learning Accounts. The inclusion of language in the General Provisions allows this funding to be available to employees whose salaries are paid through other appropriations, such as Public Health and Social Services Emergency Fund and Agency for Toxic Substances and Disease Registry.</p>

EXHIBIT F-1. AMOUNTS AVAILABLE FOR OBLIGATION

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR DISEASE CONTROL AND PREVENTION DISEASE, CONTROL, RESEARCH AND TRAINING AMOUNTS AVAILABLE FOR OBLIGATION ¹ (\$ IN 000)			
	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Estimate ²
Appropriation:			
Annual	4,547,321,536	4,533,910,000	3,940,963,000
Rescission	(31,165,000)	(36,255,722)	
HHS Reduction Pursuant to HR2673	0	(1,944,000)	
Subtotal, adjusted Appropriation	4,516,156,536	4,495,710,278	3,940,963,000
Receipts from CRADA	1,106,233	1,000,000	1,000,000
Recovery of prior year Obligations	6,992,000		
Unobligated balance start of year	165,297,338	(218,335,952)	(219,000,000)
Unobligated balance expiring	(1,043,361)		
Unobligated balance end of year	218,335,952	219,000,000	220,000,000
Total obligations	4,906,844,698	4,497,374,326	3,942,963,000

¹ Excludes the following amounts for reimbursements: FY 2004 \$568,769,000; FY 2005 \$325,015,000; and FY 2006 \$630,271,000.

² FY 2006 request is based on the proposed law to transfer \$100,000,000 from Section 317 discretionary account of the Public Health Service Act to the mandatory Vaccines for Children program.

EXHIBIT G. SUMMARY OF CHANGES

CENTERS FOR DISEASE CONTROL AND PREVENTION SUMMARY OF CHANGES				
(\$ IN 000)				
		Dollars	FTEs	
FY 2006 Estimate (Budget Authority)		\$3,940,963	8,837	
FY 2005 Appropriation (Budget Authority)		<u>\$4,495,710</u>	<u>9,087</u>	
Net Change		(\$554,747)	250	
		FY 2005 Appropriation		FY 2006 Estimate Change from Base
		FTE	Base Funding	FTE Proposed Level
Increases:				
A: Built-In/Mandatory Costs:				
1. January 2006 Pay Raise/Locality Pay @ 2.6%.....	---	---	---	10,521
2. Annualization of FY 2005 Pay Increase @ 3.5%.....	---	---	---	4,721
3. Within-Grade Increases.....	---	---	---	9,712
4. Rental Payments to GSA and Others.....	---	---	---	521
5. HHS Service & Supply Fund.....	---	---	---	1,889
6. Vaccine Price Increase.....	---	---	---	4,323
7. Inflation Costs on Other Objects @ 2.0%.....	---	---	---	21,469
8. Restoration of FY 2005 L/HHS Administration Reduction.....	---	---	---	1,634
Subtotal, Built-In/Mandatory Increases	8,408	4,495,710	N/A	54,790
B: Program Increases:				
1. Immunization 317	---	\$411,478	---	\$50,000
2. Global Disease Detection	---	\$21,426	---	\$12,077
Subtotal, Program Increases	N/A	N/A	0	\$62,077
Total Increases (Budget Authority)	8,408	\$4,495,710	0	\$116,867
Decreases:				
A. Built-In:				
1. Absorption of Current Services	---	---	---	(\$53,156)
Subtotal, Built-In/Mandatory Decreases	---	---	---	(\$53,156)
B. Program Decreases:				
1. Youth Media Campaign	---	\$58,795	---	(\$58,795)
2. Preventive Health and Health Services Block Grant	---	\$130,759	---	(\$130,759)
3. Public Health Information Network (PHIN)	---	\$9,827	---	(\$4,915)
4. Buildings and Facilities	---	\$269,708	---	(\$239,708)
5. Immunization (Proposed Law)	---	\$479,029	---	(\$100,000)
6. Congressional Projects	---	\$60,450	---	(\$60,450)
7. Business Services Support	---	\$278,838	---	(\$15,124)
8. IT Reduction	---	---	---	(\$8,707)
Subtotal, Program Decreases	N/A	N/A	0	(\$618,458)
Total Decreases (Budget Authority)	N/A	N/A	0	(\$671,614)
NET CHANGE - L/HHS/ED BUDGET AUTHORITY	8,408	\$4,495,710	0	(\$554,747)
Program Level Changes				
1. Vaccines for Children (Proposed Law)	---	\$1,634,850	---	\$7,483
2. ATSDR IT Reduction	429	\$76,041	---	(\$17)
3. PHS Evaluation Transfers	---	265,100	---	0
4. Terrorism (all inclusive)	---	\$1,560,445	---	\$56,278
<i>Upgrading State and Local Capacity (Terrorism)</i>	---	\$926,736	---	(\$129,598)
<i>Upgrading CDC Capacity (Terrorism)</i>	---	\$140,972	---	(\$748)
<i>Anthrax Research (Terrorism)</i>	---	\$16,666	---	(\$16,666)
<i>BioSurveillance Initiative (Terrorism)</i>	---	\$79,271	---	\$90
<i>Strategic National Stockpile(Terrorism)</i>	---	\$396,800	---	\$203,200
<i>IT Reduction (Terrorism - non add)</i>	---	---	---	(\$816)
<i>Administrative Savings (Terrorism - non add)</i>	---	---	---	(\$175)
5. User Fees	---	\$2,226	---	\$0
Total - Program Level Net Increase	429	\$3,538,662	0	\$63,744
NET CHANGE: BUDGET AUTHORITY & PROGRAM LEVEL	8,837	8,034,372	0	(\$491,003)

EXHIBIT H. BUDGET AUTHORITY BY ACTIVITY (ALL PURPOSE TABLE)

Centers for Disease Control and Prevention <i>All-Purpose Table Reflecting New Budget Structure</i> (Dollars in Thousands)				
Budget Activity	FY 2004 Actual	FY 2005 Enacted	FY 2006 Estimate	FY 2006 +/- FY 2005 Enacted
Infectious Diseases (includes PHS Evaluation Transfer) (Current Law)				
Budget Authority	\$1,641,600	\$1,652,536	\$1,696,964	\$44,429
PHS Evaluation Transfers	\$12,794	\$12,794	\$12,794	\$0
Subtotal, Infectious Diseases (Current Law) -	\$1,654,394	\$1,665,330	\$1,709,758	\$44,429
Infectious Diseases (includes PHS Evaluation Transfer) (Proposed Law)				
Budget Authority	\$1,641,600	\$1,652,536	\$1,596,964	(\$55,571)
PHS Evaluation Transfers	\$12,794	\$12,794	\$12,794	\$0
Subtotal, Infectious Diseases (Proposed Law) ¹ -	\$1,654,394	\$1,665,330	\$1,609,758	(\$55,571)
Health Promotion	\$932,067	\$1,024,033	\$964,421	(\$59,612)
Health Information and Service (includes PHS Evaluation Transfer)				
Budget Authority	\$95,247	\$94,438	\$89,564	(\$4,874)
PHS Evaluation Transfers	\$115,269	\$134,235	\$134,235	\$0
Subtotal, Health Information and Service -	\$210,516	\$228,673	\$223,799	(\$4,874)
Environmental Health and Injury	\$282,925	\$285,721	\$284,820	(\$902)
Occupational Safety and Health (includes PHS Evaluation Transfer)				
Budget Authority	\$241,307	\$198,970	\$198,859	(\$111)
PHS Evaluation Transfers	\$35,681	\$87,071	\$87,071	\$0
Subtotal, Occupational Safety and Health -	\$276,988	\$286,041	\$285,930	(\$111)
Global Health²	\$285,983	\$293,863	\$306,079	\$12,216
Public Health Research (includes PHS Evaluation Transfer)				
Budget Authority	\$29,107	\$0	\$0	\$0
PHS Evaluation Transfers	\$0	\$31,000	\$31,000	\$0
Subtotal, Public Health Research -	\$29,107	\$31,000	\$31,000	\$0
Public Health Improvement and Leadership (includes PHS Transfer)				
Budget Authority	\$215,387	\$266,843	\$206,541	(\$60,302)
PHS Evaluation Transfers	\$17,436	\$0	\$0	\$0
Subtotal, Public Health Improvement and Leadership -	\$232,824	\$266,843	\$206,541	(\$60,302)
Prev. Health & Health Services Block Grant	\$131,814	\$130,759	\$0	(\$130,759)
Buildings and Facilities	\$260,454	\$269,708	\$30,000	(\$239,708)
Business Services Support (includes PHS Evaluation Transfer)				
Budget Authority	\$251,273	\$278,840	\$263,715	(\$15,126)
PHS Evaluation Transfers	\$30,953	\$0	\$0	\$0
Subtotal, Business Services Support -	\$282,226	\$278,840	\$263,715	(\$15,126)
National Institute for Occupational Safety and Health BSS (non-inclusive).....	\$46,950	\$46,950	\$46,950	\$0
Agency for Toxic Substances and Disease Registry BSS (non-inclusive).....	\$12,092	\$12,092	\$12,092	\$0
Terrorism BSS (non-inclusive).....	\$23,446	\$23,446	\$23,446	\$0
Vaccines for Children BSS (non-inclusive).....	\$20,253	\$20,253	\$20,253	\$0
Total, L/HHS/ED (Current Law) -	\$4,367,165	\$4,495,711	\$4,040,963	(\$454,749)
Total, L/HHS/ED (Proposed Law) ¹ -	\$4,367,165	\$4,495,711	\$3,940,963	(\$554,749)
Total, L/HHS/ED (includes PHS Evaluation Transfer) (Current Law) -	\$4,579,299	\$4,760,811	\$4,306,063	(\$454,749)
Total, L/HHS/ED (includes PHS Evaluation Transfer) (Proposed Law) ¹ -	\$4,579,299	\$4,760,811	\$4,206,063	(\$554,749)
PHS Evaluation Transfer (non-add)	\$212,134	\$265,100	\$265,100	\$0
Agency for Toxic Substances and Disease Registry	\$73,034	\$76,041	\$76,024	(\$17)
Terrorism	\$1,507,211	\$1,560,445	\$1,616,723	\$56,278
Vaccines for Children (Current Law) ³	\$1,052,030	\$1,634,850	\$1,502,333	(\$132,517)
Vaccines for Children (Proposed Law) ^{1,3}	\$1,052,030	\$1,634,850	\$1,642,333	\$7,483
User Fees	\$2,226	\$2,226	\$2,226	\$0
Total, CDC/ATSDR Program Level (Current Law) -	\$7,213,800	\$8,034,373	\$7,503,369	(\$531,004)
Total, CDC/ATSDR Program Level (Proposed Law) ¹ -	\$7,213,800	\$8,034,373	\$7,543,369	(\$491,004)

¹The FY 2006 budget request reflects the Proposed Law transfer of \$100 million from the discretionary Section 317 Program to the mandatory Vaccines For Children program.

²Funding levels for FY 2004 are shown on a comparable basis. A total of \$148,992 million was removed from FY 2004 to reflect the transfer of the President's International Mother and Child HIV Prevention Initiative (PMTCT) from CDC to the Department of State Office of the Global AIDS Coordinator.

³Funding for VFC in FY 2004 reflects obligations. FY 2005 funding includes carryover of \$166 million from FY 2004.

EXHIBIT H-1. SUPPLEMENTAL BUDGET AUTHORITY BY ACTIVITY (SUPP. ALL PURPOSE TABLE)

Centers for Disease Control and Prevention				
<u>All-Purpose Table Reflecting New Budget Structure</u>				
(Dollars in Thousands)				
Budget Activity	FY 2004 Actual	FY 2005 Enacted	FY 2006 Estimate	FY 2006 +/- FY 2005 Enacted
<u>Infectious Diseases (includes PHS Evaluation Transfer) (Current Law)</u>				
Budget Authority	\$1,641,600	\$1,689,342	\$1,696,964	\$7,623
PHS Evaluation Transfers	\$12,794	\$12,794	\$12,794	\$0
Subtotal, Infectious Diseases (Current Law) -	\$1,654,394	\$1,702,136	\$1,709,758	\$7,623
<u>Infectious Diseases (includes PHS Evaluation Transfer) (Proposed Law)</u>				
Budget Authority	\$1,641,600	\$1,689,342	\$1,596,964	(\$92,377)
PHS Evaluation Transfers	\$12,794	\$12,794	\$12,794	\$0
Subtotal, Infectious Diseases (Proposed Law) ¹ -	\$1,654,394	\$1,702,136	\$1,609,758	(\$92,377)
Health Promotion	\$932,067	\$1,011,800	\$964,421	(\$47,379)
<u>Health Information and Service (includes PHS Evaluation Transfer)</u>				
Budget Authority	\$95,247	\$94,438	\$89,564	(\$4,874)
PHS Evaluation Transfers	\$115,269	\$134,235	\$134,235	\$0
Subtotal, Health Information and Service -	\$210,516	\$228,673	\$223,799	(\$4,874)
Environmental Health and Injury	\$282,925	\$285,721	\$284,820	(\$902)
<u>Occupational Safety and Health (includes PHS Evaluation Transfer)</u>				
Budget Authority	\$241,307	\$198,970	\$198,859	(\$111)
PHS Evaluation Transfers	\$35,681	\$87,071	\$87,071	\$0
Subtotal, Occupational Safety and Health -	\$276,988	\$286,041	\$285,930	(\$111)
Global Health²	\$285,983	\$293,863	\$306,079	\$12,216
<u>Public Health Research (includes PHS Evaluation Transfer)</u>				
Budget Authority	\$29,107	\$0	\$0	\$0
PHS Evaluation Transfers	\$0	\$31,000	\$31,000	\$0
Subtotal, Public Health Research -	\$29,107	\$31,000	\$31,000	\$0
<u>Public Health Improvement and Leadership (includes PHS Transfer)</u>				
Budget Authority	\$215,387	\$266,843	\$206,541	(\$60,302)
PHS Evaluation Transfers	\$17,436	\$0	\$0	\$0
Subtotal, Public Health Improvement and Leadership -	\$232,824	\$266,843	\$206,541	(\$60,302)
Prev. Health & Health Services Block Grant	\$131,814	\$118,526	\$0	(\$118,526)
Buildings and Facilities	\$260,454	\$269,708	\$30,000	(\$239,708)
<u>Business Services Support (includes PHS Evaluation Transfer)</u>				
Budget Authority	\$251,273	\$278,840	\$263,715	(\$15,125)
PHS Evaluation Transfers	\$30,953	\$0	\$0	\$0
Subtotal, Business Services Support -	\$282,226	\$278,840	\$263,715	(\$15,125)
National Institute for Occupational Safety and Health BSS (non-inclusive).....	\$46,950	\$46,950	\$46,950	\$0
Agency for Toxic Substances and Disease Registry BSS (non-inclusive).....	\$12,092	\$12,092	\$12,092	\$0
Terrorism BSS (non-inclusive).....	\$23,446	\$23,446	\$23,446	\$0
Vaccines for Children BSS (non-inclusive).....	\$20,253	\$20,253	\$20,253	\$0
Total, L/HHS/ED (Current Law) -	\$4,367,165	\$4,508,051	\$4,040,963	(\$467,088)
Total, L/HHS/ED (Proposed Law) ¹ -	\$4,367,165	\$4,508,051	\$3,940,963	(\$567,088)
Total, L/HHS/ED (includes PHS Evaluation Transfer) (Current Law) -	\$4,579,299	\$4,773,150	\$4,306,063	(\$467,088)
Total, L/HHS/ED (includes PHS Evaluation Transfer) (Proposed Law) ¹ -	\$4,579,299	\$4,773,150	\$4,206,063	(\$567,088)
PHS Evaluation Transfer (non-add)	\$212,134	\$265,100	\$265,100	\$0
Agency for Toxic Substances and Disease Registry	\$73,034	\$76,041	\$76,024	(\$17)
Terrorism	\$1,507,211	\$1,560,445	\$1,616,723	\$56,278
Vaccines for Children (Current Law) ³	\$1,052,030	\$1,634,850	\$1,502,333	(\$132,517)
Vaccines for Children (Proposed Law) ^{1,3}	\$1,052,030	\$1,634,850	\$1,642,333	\$7,483
User Fees	\$2,226	\$2,226	\$2,226	\$0
Total, CDC/ATSDR Program Level (Current Law) -	\$7,213,800	\$8,046,713	\$7,503,369	(\$543,344)
Total, CDC/ATSDR Program Level (Proposed Law) -	\$7,213,800	\$8,046,713	\$7,543,369	(\$503,344)

¹The FY 2006 budget request reflects the Proposed Law transfer of \$100 million from the discretionary Section 317 Program to the mandatory Vaccines For Children program.

²Funding levels for FY 2004 are shown on a comparable basis. A total of \$148,992 million was removed from FY 2004 to reflect the transfer of the President's International Mother and Child HIV Prevention Initiative (PMTCT) from CDC to the Department of State Office of the Global AIDS Coordinator.

³Funding for VFC in FY 2004 reflects obligations. FY 2005 funding includes carryover of \$166 million from FY 2004.

EXHIBIT I. BUDGET AUTHORITY BY OBJECT

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR DISEASE CONTROL AND PREVENTION OBJECT CLASSIFICATION- DIRECT OBLIGATIONS (\$ IN 000)			
	FY 2005 Appropriation	FY 2006 Estimate	FY 2006 +/- FY 2005
Personnel Compensation:			
Full-Time Permanent(11.1)	365,029	380,514	15,485
Other than Full-Time Permanent (11.3)	41,398	43,154	1,756
Other Personnel Comp. (11.5)	24,738	25,788	1,049
Military Personnel (11.7)	57,158	58,186	1,029
Special Personal Service Comp. (11.8)	1,273	1,292	19
Total Personnel Compensation	489,596	508,934	19,338
Civilian personnel Benefits (12.1)	118,130	123,141	5,011
Military Personnel Benefits (12.2)	32,985	33,579	594
Benefits to Former Personnel (13.0)	769	781	12
SubTotal Pay Costs	641,481	666,435	24,954
Travel (21.0)	42,864	39,940	(2,924)
Transportation of Things (22.0)	9,395	8,754	(641)
Rental Payments to GSA (23.1)	32,143	32,143	0
Rental Payments to Others (23.2)	1,937	1,937	0
Communications, Utilities, and Misc. Charges (23.3)	24,824	23,131	(1,693)
Printing and Reproduction (24.0)	6,459	6,018	(441)
Other Contractual Services:			
Advisory and Assistance Services (25.1)	228,824	213,215	(15,609)
Other Services (25.2)	114,291	62,495	(51,796)
Purchases from Government Accounts (25.3)	310,892	289,684	(21,208)
Operation and Maintenance of Facilities (25.4)	46,827	23,633	(23,194)
Research and Development Contracts (25.5)	137,243	137,243	0
Medical Services (25.6)	786	786	0
Operation and Maintenance of Equipment (25.7)	21,889	20,396	(1,493)
Subsistence and Support of Persons (25.8)	0	0	0
Subtotal Other Contractual Services	860,752	747,452	(113,300)
Supplies and Materials (26.0)	30,805	28,702	(2,103)
Equipment (31.0)	98,327	51,620	(46,707)
Land and Structures (32.0)	156,292	20,000	(136,292)
Investments and Loans (33.0)	0	0	0
Grants, Subsidies, and Contributions (41.0)	2,590,182	2,314,582	(275,600)
Insurance Claims and Indemnities (42.0)	248	248	0
Interest and Dividends (43.0)	0	0	0
Refunds (44.0)	0	0	0
Subtotal Non-Pay Costs	3,854,229	3,274,528	(579,701)
Total Budget Authority	4,495,710	3,940,963	(554,747)

EXHIBIT J. SALARIES AND EXPENSES

DEPARTMENT OF HEALTH AND HUMANS SERVICES CENTERS FOR DISEASE CONTROL AND PREVENTION SALARIES AND EXPENSES (\$ IN 000)			
	FY 2005 Appropriation	FY 2006 Estimate	FY 2006 +/- FY 2005
Personnel Compensation:			
Full-Time Permanent (11.1)	365,029	380,514	15,485
Other than Full-Time Permanent (11.3)	41,398	43,154	1,756
Other personnel Comp. (11.5)	24,738	25,788	1,049
Military Personnel (11.7)	57,158	58,186	1,029
Special Personal Service Comp. (11.8)	1,273	1,292	19
Total Personnel Compensation -	489,596	508,934	19,338
Civilian Personnel Benefits (12.1)	118,130	123,141	5,011
Military Personnel Benefits (12.2)	32,985	33,579	594
Benefits to Former Personnel (13.0)	769	781	12
Subtotal Pay Costs -	641,481	666,435	24,954
Travel (21.0)	42,864	39,940	(2,924)
Transportation of Things (22.0)	9,395	8,754	(641)
Rental Payments to others (23.2)	1,937	1,937	0
Communications, Utilities, and Misc. Charges (23.3)	24,824	23,131	(1,693)
Printing and Reproduction (24.0)	6,459	6,018	(441)
Other Contractual Services:			
Advisory and Assistance Services (25.1)	57,162	38,120	(19,042)
Other Services (25.2)	114,291	62,495	(51,796)
Purchases from Government Accounts (25.3)	42,855	16,286	(26,569)
Operation and Maintenance of Facilities (25.4)	39,952	16,620	(23,332)
Medical Services (25.6)	786	786	0
Operation and Maintenance of Equipment (25.7)	21,889	20,396	(1,493)
Subsistence and Support of Persons (25.8)	0	0	0
Subtotal Other Contractual Services -	276,934	291,946	15,012
Supplies and materials (26.0)	30,805	28,702	(2,103)
Subtotal Non-Pay Costs -	393,219	263,186	(130,033)
Total Salaries and Expenses -	1,034,700	929,621	(105,079)

EXHIBIT K. SIGNIFICANT ITEMS IN COMMITTEE REPORTS-HOUSE

**SIGNIFICANT ITEMS FOR INCLUSION IN
THE FY 2006 CONGRESSIONAL JUSTIFICATION
AND OPENING STATEMENTS
HOUSE REPORT NO. 108-636
CENTERS FOR DISEASE CONTROL AND PREVENTION**

Item

Autism – The Committee is aware of the progress that has been made with the autism programs at the CDC. The Committee acknowledges the importance of this work in the area of autism surveillance and research and urges it to continue in a timely manner. (Page 44)

Action taken or to be taken

CDC agrees that autism surveillance and research activities are extremely important. CDC submitted a report to Congress on some of the challenges to timely collection and analysis of autism surveillance data, but is continuing to finalize data for the subsequent data point for its Atlanta program and to work with the network of states collecting autism data in their communities. CDC plans to publish another prevalence study in 2005 to update previous figures and address differences from earlier rates. This will be an important source of information on autism trends. In addition, CDC is continuing to move forward with a large, collaborative study on the causes of and risk factors of autism. The protocol for this activity has been developed and approved, and it is ready to be implemented at the research centers.

Item

Diamond Blackfan Anemia (DBA) – The Committee encourages the CDC to establish a public health outreach and surveillance program for Diamond Blackfan Anemia as authorized under Title III of the Public Health Services Act. (Page 44)

Action taken or to be taken

CDC will work with representatives from the Daniella Maria Arturi (DBA) Foundation. The DBA Foundation and the Schneider's Children's Hospital are to design an outreach, education and surveillance program for individuals with DBA. The program will build upon an existing DBA registry maintained by Schneider's Children's Hospital.

Item

Duchenne and Becker Muscular Dystrophy – The Committee is concerned with the pace of the development of the CDC Birth Defects Surveillance program covering the muscular dystrophies and is aware that the agency has made the commitment to enhance the internal staff commitment to the program. The Committee is encouraged by that new commitment and expects that CDC dedicate its efforts to organize, coordinate and implement the agency's Duchenne MD surveillance program. (Page 44)

Action taken or to be taken

CDC is working with partners in state health departments and universities in Arizona, Colorado, Iowa, and western New York to develop surveillance systems for Duchenne and Becker Muscular Dystrophy (DBMD). The goal of the project is to determine the incidence of DBMD in the United States and to identify preventable risk factors for secondary complications. In April 2004, data collection began in all four states. An additional state will be added to the system in spring 2005. Other projects currently supported by CDC include research in early identification of DBMD via voluntary newborn or infant screening; needs assessments of people with DBMD and their families; and research on the knowledge, beliefs and behaviors of carrier females toward preventive cardiac care. CDC will also use the funds to hire additional contracted staff to help support these activities.

Item

Folic Acid – The Committee is pleased to learn that severe brain and spinal defects have dropped 27 percent in the U.S. since certain food producers have been required to fortify their foods with folic acid. The Committee encourages CDC to work with producers of suitable ethnic foods, such as tortillas, so ethnic populations may also benefit from folic acid fortification. (Page 45)

Action taken or to be taken

Spinal bifida and anencephaly—neural tube defects largely preventable through consumption of folic acid—remain high among certain groups, particularly Hispanics. CDC shares the committee's view of the urgency of reaching groups at higher risk for folic-acid preventable birth defects and will work to reach such populations through pursuing manufacturers' voluntary fortification of ethnic foods and through targeted health marketing programs.

Item

Fragile X – The Committee supports the CDC's focus on maximizing prevention potential, minimizing impact on families and promoting early intervention through developmental screening and encourages CDC to incorporate individuals affected by fragile X. In addition, the Committee encourages the CDC to consider developing a fragile X public health program to expand surveillance and epidemiological study of fragile X, as well as provide patient and provider outreach on fragile X syndrome and other developmental disabilities. (Page 45)

Action taken or to be taken

CDC shares the Committee's concern regarding Fragile X syndrome, as it is one of the most common forms of inherited mental retardation. The agency is working with the Fragile X Foundation and others to design epidemiologic and surveillance studies to determine the prevalence and incidence of this condition, as well as the socioeconomic impact on families. In addition, CDC is exploring efforts to improve early identification and access to appropriate intervention for those with Fragile X syndrome.

Item

Hemophilia – The Committee urges CDC to continue working closely with voluntary health organizations, such as the National Hemophilia Foundation, concerned about carrying out disease management, prevention, outreach, and blood safety surveillance programs for persons with bleeding and clotting disorders. The Committee encourages the CDC to maintain its support for surveillance of the bleeding disorders community to address concerns about inhibitor development and prevention within this population. (Page 45)

Action taken or to be taken

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

Item

Limb Loss Information Center – The Committee recognizes that one of the greatest challenges facing individuals with limb loss is access to necessary health and rehabilitative services. The Committee urges CDC to work with the Amputee Coalition of America (ACA) to identify strategies to remove these barriers. (Page 45)

Action taken or to be taken

Nearly 12 million people in the United States have an extremity absence, or limb loss. This is a prevalence rate of 4.9 per 1,000 persons with a limb loss. Limb loss often results in reduced mobility and increased reliance on prosthesis for daily activities like walking and climbing stairs. People with limb loss may be at increased risk for pressure sores, muscle atrophy, depression and obesity. CDC is fully committed to continuing its work with the Amputee Coalition of America to identify and address such barriers as available resources allow. CDC continues to fund the Limb Loss Information Center through ACA. CDC also supports research examining the consequences of limb loss and the impact of social support among people with limb loss.

Item

Tourette Syndrome – The Committee commends CDC for its partnership with the national Tourette Syndrome Association (TSA) in developing a public health education and research program and has provided \$2,000,000 in FY 2005 to continue to educate parents, physicians, educators and other health care workers about the disorder and to expand on the scientific knowledge base on prevalence, risk factors and co-morbidities of Tourette Syndrome (TS). The Committee intends that these resources be used to support the partnership between the TSA and CDC. (Page 46)

Action taken or to be taken

Tourette Syndrome (TS) is an inherited, neurological disorder characterized by multiple involuntary movements, called motor tics, and uncontrollable vocalizations called vocal or phonic tics. Many studies have linked TS and tic disorders to higher rates of Attention Deficit/Hyperactivity Disorder, obsessive-compulsive disorder, and other impairments. CDC has established a partnership with the TSA in support of a Tourette Syndrome Education and Outreach to Service Providers. Through this cooperative agreement, CDC has been working with TSA to bolster provider education and intensive training for healthcare professionals on how to identify, diagnosis, and treat TS. To further understand the prevalence, risk factors, and comorbidities of TS, CDC in collaboration with investigators from the University of Oklahoma Health Sciences Center has initiated a pilot epidemiology study of TS and tics in school-age children. Results from this pilot study are expected by late 2006. Additionally, CDC is supporting extramural research that will identify factors contributing to the quality of life of persons with TS. This work is a collaborative effort with the Association of University Centers on Disabilities, the University of Washington, and CDC scientists. In FY 2005, CDC received an additional \$500,000 to support these activities.

Item

Vision Loss – The Committee encourages the Director to consider the creation of a National Information Center on Vision Loss to address the need for appropriate public health information to prevent further impairment and disability among individuals who are blind or who have low vision. The Committee further encourages CDC to partner with a national non-profit organization that is recognized for leadership in providing information to persons who are blind or visually impaired, including published resource guides, directories of services for consumers in the field, scholarly journals on blindness and vision loss, assistive technology magazines, and talking books. Particular attention should be paid to entities that have successfully implemented interactive and accessible information resources or comprehensive libraries for persons who are blind or visually impaired. **(Page 46)**

Action taken or to be taken

An estimated 8.3 million people in the United States experience vision impairment. Most vision impairment is acquired in adulthood or in later years. Rates of vision loss range from 2 per 1000 for those under age 10 years to 250 per 1000 for those over 85 years. Recent investigations reveal that older people with vision loss experience higher rates of heart disease, diabetes, hypertension, stroke, falls and broken hips. The population of people experiencing vision loss is expected to grow as the nation ages. CDC recognizes vision loss as a significant public health issue. CDC will work to build relationships with new partners and will continue to strengthen existing relationships with national non profit organizations, such the American Foundation for the Blind.

Item

Chronic Disease Prevention and Health Promotion - The Committee recognizes the essential infrastructure that CDC has built in state health departments and encourages CDC to expand its state-based leadership in surveillance, public health education, communications and model programs and research. **(Page 46)**

Action taken or to be taken

CDC appreciates the Committee's support for its state-based chronic disease prevention and health promotion programs. Seven of ten deaths, or more than 1.7 million deaths, are caused by chronic diseases each year. Our nation spends more on health care than any other country in the world, over \$1.3 trillion annually, and two-thirds of these costs are directly related to care for chronic diseases. There are many existing opportunities that we have not taken complete advantage of to prevent chronic disease. These include: the use of early detection practices for cancer, diabetes, and heart disease; school health education programs; supportive environments for physical activity and healthy eating in communities; and established standards for preventive care practices.

CDC will continue to expand its leadership in the development of strong public health programs at the state, local, community and national levels to target the leading causes of death and their principal risk factors. This effort should include public health agencies with a strong focus on the aging population, adolescents, and those at highest risk for disease; and research in community settings to translate effective policy interventions that benefit individuals and their families. These programs include state-based disease prevention and health promotion programs, and community-based demonstrations such as Steps to a HealthierUS.

Item

Alzheimer's Disease – The Committee encourages the CDC to work with the NIH to further research and investigate links between a healthy lifestyle and the prevention of Alzheimer's disease in an effort to develop an Alzheimer's specific segment of the Healthy Aging Program. The ultimate goal of the Alzheimer's Program would be to

aggressively educate the public and health professionals as to research-based ways to reduce the risks of developing Alzheimer's by maintaining a healthy lifestyle. **(Page 47)**

Action taken or to be taken

CDC will use FY 2005 funding to work with key partners including the NIH, the Administration on Aging, and the Alzheimer's Association to identify research-based healthy lifestyle strategies that reduce the risk of Alzheimers. CDC would then develop and launch a website, fact sheets and brochures to educate the targeted populations about the healthy lifestyle strategies.

In addition, CDC will review and summarize the quality of available evidence on essential community preventive lifestyles interventions with relevance to Alzheimer's disease. This would be conducted through CDC's aging-focused Prevention Research Centers following guidance from the Task Force on the Guide for Community Preventive Services. As a result of the evidence review, CDC's grants program could be expanded to include evidence-based pilot projects that utilize healthy lifestyles as a strategy to reduce the risk of Alzheimer's disease.

Finally, CDC has collaborated with the National Institute on Aging (NIA) to examine the incidence, prevalence, and associated risk factors for Alzheimer's disease through a study conducted in a low-income area of east Boston. Data derived from this study allowed researchers to estimate that approximately 13 million Americans will have Alzheimer's disease by 2050. CDC is working on a study supported through the National Institute on Aging (NIA) to examine the distribution of Alzheimer's disease in a geographically-defined, biracial area of Chicago.

Item

Breast and Cervical Cancer Screening – Given the high vacancy rates of qualified laboratory personnel who prepare and interpret tissue and cell samples, the Committee encourages CDC to consider expanding its education component and develop a partnership with HRSA's Allied Health and Special Projects program. **(Page 47)**

Action taken or to be taken

CDC recognizes the importance of HRSA's Allied Health and Special Projects program for training needed allied health professionals. CDC will share lessons learned on educating health care professionals, through the National Breast and Cervical Cancer and Early Detection Program (NBCCEDP), with HRSA's Allied Health and Special Projects program.

The NBCCEDP partners with HRSA's Community Health Centers (CHC) both at the national and local level. This collaboration is an excellent example of federal programs working well together to better serve women in need. At the national level, CDC supports HRSA Community Center Collaborative. These collaboratives draw on CDC's expertise in partnership development and quality assurance to provide training for community health centers on how to improve their delivery of cancer screening services. At the local level, NBCCEDP programs provide much needed and appreciated complementary assistance to CHC operations by providing community outreach, supporting case management services, assisting in quality assurance activities, and training in breast and cervical cancer screening services (such as performance of clinical breast exams). They are often the only source for mammography services in the community. At each state/tribe and territory level, the local program has to find and maintain a network of providers willing to serve eligible women throughout the locale. This NBCCEDP network is often made up of a combination of local health departments, private providers, public hospitals and providers and community health centers. There are approximately 21,000 providers currently serving women in this program.

Item

Childhood and Adolescent Obesity – The Committee recognizes that childhood and adolescent obesity is a serious and growing health concern. It is linked to the recent rise in Type 2 diabetes and exposes them to greater risk for 42 diseases as an adult, including coronary heart disease and some cancers. The Committee urges the CDC to undertake an epidemiological study of the long-term impact of childhood and adolescent obesity. The Committee also encourages the CDC to fund school and community pilot programs that will increase nutritional awareness and that emphasize the importance of limiting non-nutritive carbohydrates. **(Page 47)**

Action taken or to be taken

CDC continues to monitor surveillance data to identify the long-term impact of childhood and adolescent obesity. CDC has published epidemiological studies demonstrating that 60% of overweight 5 to 10 year-olds had at least one cardiovascular disease risk, such as elevated blood pressure, elevated insulin, or abnormal lipid profile with increased LDL or decreased HDL cholesterol. In addition, 25% of overweight 5 to 10 year-olds have two or more cardiovascular (CVD) risk factors. Concern about the impact of persistent obesity makes children another important target for prevention. While 25% of adult obesity begins in childhood, childhood onset obesity that persists is more severe in adults. Economic modeling studies, comparing the relative costs and effectiveness of various strategies

(e.g., primary prevention programs for children or weight loss treatment programs for adults) are now needed to understand how to best utilize available resources.

CDC currently funds 28 states to implement nutrition and physical activity strategies to prevent obesity and other chronic diseases. All states are planning or currently implementing pilot studies or interventions to support policy and environmental changes to support eating healthfully and being physically active. For example, a series of interventions in Moses Lake, Washington, known collectively as *Healthy Communities Moses Lake*, is encouraging good nutrition and physical activity behaviors through a comprehensive program of environmental and policy change. The city has incorporated a community garden project into its parks and recreation department work plan, providing project participants with greater access to fresh, nutritious produce as well as physical activity opportunities by working in the gardens. To encourage good nutrition from birth, *Healthy Communities* aims to inform residents about proper breastfeeding practices as well as create supportive environments for nursing mothers throughout the community. The city has adopted a master plan to replace a railroad track that runs through downtown with a path for biking and walking, while Grant County, which includes Moses Lake, has a plan for creating walking and biking trails alongside irrigation canals. New zoning ordinances in both the city and county require wider sidewalks that will increase accessibility for pedestrians and cyclists.

Another example includes the Nutrition and Physical Activity Self-Assessment for Child Care (NAP-SACC) in North Carolina, a pilot intervention in child care centers aimed at improving nutrition and physical activity environments and practices through self-assessment and targeted technical assistance. Participating facilities were able to make positive improvements in physical activity through, for example, the purchase of additional equipment or creation of additional indoor and outdoor play space. Improvements in nutrition included an increased availability of fruits and vegetables, fewer fried foods and sugar-sweetened beverages, and new overall nutrition policies in individual centers.

Item

Colorectal Cancer – The Committee is very pleased with the leadership of CDC’s National Colorectal Cancer Roundtable in promoting the availability and advisability of screening to both health care providers and the general public. The Committee encourages the CDC to continue to expand its partnerships with state health departments, professional and patient organizations, and private industry to combat this devastating disease. **(Page 47)**

Action taken or to be taken

CDC will continue to support and promote national colorectal cancer screening by educating health care providers and the public about the benefits of screening, the availability of screening procedures, and screening guidelines. CDC continues to work with the National Colorectal Cancer Roundtable to promote screening to health care providers and the general public and will expand its partnerships with state health departments, professional and patient organizations, and private industry.

CDC educates Americans aged 50 years or older about the importance of colorectal cancer screening through the national colorectal cancer action campaign, *Screen for Life*. To raise primary care providers’ awareness and knowledge about the prevention and early detection of colorectal cancer, CDC developed an online training program, *A Call To Action*. Both of these efforts increase awareness and educate target populations about the importance of colorectal cancer screening.

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

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

Item

Diabetes – The Committee applauds CDC for its new cooperative agreement with the American Association of Diabetes Educators (AADE), which is intended to ensure early diagnoses of people with diabetes and the best treatment and care of those trying to manage the disease. The Committee encourages CDC to work in partnership with AADE to identify strategies for evaluating the effectiveness of diabetes education in improving the self-care of people with diabetes and in reducing risk factors for diabetes. **(Page 47)**

Action taken or to be taken

CDC has conducted an intensive review of diabetes self management interventions and the findings have been published in the Guide to Community Preventive Services. Based on this evidence-based review, CDC found that diabetes self-management resulted in improve glycemic control following the interventions, but the improvements faded overtime. CDC encourages AADE to partner with an academic institution to develop a research proposal to further study the effectiveness of diabetes education for self-management of persons with diabetes. CDC would support AADE's efforts to identify federal and non-federal funding streams to support the proposal.

CDC's diabetes program continues to work closely with AADE under a formal Memorandum of Understanding to (1) improve access to and outcomes of diabetes care and education in rural settings, (2) collaborate on the National Public Health Initiative on Diabetes and Women's Health, (3) collaborate on surveillance systems and data collection, (4) hold reciprocal sessions at annual conferences, and (5) explore opportunities for collaboration on the primary prevention of diabetes.

Item

Inflammatory Bowel Disease (IBD) – For the past five years, the Committee has encouraged CDC to work in partnership with the IBD community to establish a national IBD epidemiology program to further our understanding of these diseases. The Committee understands that the Crohn's and Colitis Foundation of America (CCFA) have provided financial support through the CDC Foundation to initiate this important program. Now that the project is established, the Committee encourages CDC to contribute to the project in order to expand the work in FY2005. **(Page 48)**

Action taken or to be taken

For the past five years CDC has worked with the CCFA and the Paratuberculosis Awareness and Research Association (PARA) to better define and understand IBD. CDC also worked with multiple federal agencies to identify gaps in scientific knowledge on IBD and guide CDC efforts in this area. In FY 2003, CDC delivered a report on IBD to Congress, updated in FY 2004. In FY 2004, CDC began final analyses characterizing national IBD hospitalizations through CDC surveillance data and is completing that final report with manuscripts. Guided by preliminary findings from the CDC pilot analysis of a large non-federal healthcare database, CDC has since collaborated with a national network of geographically and racially/ethnically diverse managed healthcare organizations to better define the epidemiology of IBD in the United States.

Item

Interstitial Cystitis (IC) – The Committee encourages the CDC to formalize its partnership with a national non-profit voluntary health association dedicated to assisting persons with IC. This would allow the CDC to develop a long term, sustainable awareness campaign that has a measurable impact on patients, physicians, researchers and the general public. **(Page 48)**

Action taken or to be taken

In 2005, CDC will work with a national non-profit voluntary health association to form a partnership focused on creating awareness about IC.

Item

Lung Cancer – The Committee encourages the CDC through its Cancer Registries program and in coordination with the Comprehensive Cancer Control program to conduct a study, or studies, that would examine: the current trends of lung cancer screening and evaluate the number of people currently getting screened for lung cancer; how lung cancer screening is being promoted; which screening methods are being promoted; how the benefits and risks of screening are communicated by health professionals to at risk populations; trends in the number of biopsies being performed following screening exams; and trends in the stage of lung cancer diagnosis. **(Page 48)**

Action taken or to be taken

CDC will continue to address cancer control, including lung cancer, through the National Program of Cancer Registries. Currently, the program collects medical record data on diagnoses, tumor biology, and initial course of treatment. As a component of the registry, data on mortality and trends in lung cancer incidence are collected. CDC offers public health information regarding lung cancer on its website. CDC will continue to work with its partners to assure this critical information on the website remains current, appropriate and evidence based in offering the best information available to the public on understanding and preventing lung cancer. CDC plans to increase the funding and number of programs for comprehensive cancer control activities. The ongoing evaluation of comprehensive cancer control activities will provide a foundation for establishing systems that address crosscutting issues in cancer

prevention and control, to include lung cancer, as well as improving effective use of limited resources to reduce the burden of cancer.

Before CDC could conduct a study or studies related to lung cancer, CDC would have to determine the feasibility (costs) and utility for addressing lung cancer studies and how this information might impact or contribute to the reduction of lung cancer morbidity and mortality in the U.S. CDC would also have to assess how best to address lung cancer from a public health perspective. The necessary steps to developing the appropriate public health response would require that CDC first work with partners and experts in the field of lung cancer to determine if these studies are the most appropriate actions to take against lung cancer at this time. The U.S. Preventive Services Task Force (USPSTF) concludes that the evidence is insufficient to recommend for or against screening asymptomatic persons for lung cancer with either low dose computerized tomography (LDCT), chest x-ray (CXR), sputum cytology, or a combination of these tests.

The USPSTF found fair evidence that screening with LDCT, CXR, or sputum cytology can detect lung cancer at an earlier stage than lung cancer would be detected in an unscreened population; however, the USPSTF found poor evidence that any screening strategy for lung cancer decreases mortality.

The most significant strategy in reducing the burden of lung cancer is to support tobacco control efforts. Lung cancer is the most common form of cancer in the world today, accounting for 12.3% of all cancers and 17.8% of cancer-related deaths worldwide in 2000. Tobacco smoking has long been known to be the primary risk factor for this cancer. There is a known dose-response relationship between lung cancer risk and the number of cigarettes smoked and the duration of smoking; a lifetime smoker has a lung cancer risk 20-30 times that of a non-smoker.

CDC will continue to lead and coordinate strategic efforts aimed at preventing tobacco use among youth, promoting smoking cessation among youth and adults, protecting nonsmokers from environmental tobacco smoke, and eliminating tobacco-related health disparities. These activities serve not only to further the goal of lung cancer control, but also to decrease morbidity and mortality from other tobacco-related conditions.

Item

Oral Health – The Committee also expects the Division to advance efforts to reduce the disparities and the health burden from oral cancers and oral diseases that are closely linked to chronic diseases like diabetes and heart disease. (Page 48)

Action taken or to be taken

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

Item

Pulmonary Hypertension – The Committee continues to be interested in pulmonary hypertension (PH), a rare, progressive and fatal disease that predominantly affects women, regardless of age or race. Because early detection of PH is critical to a patient's survival and quality of life, the Committee continues to encourage CDC to give priority consideration to supporting a cooperative agreement with the PH community designed to foster greater awareness of the disease. (Page 49)

Action taken or to be taken

Because early diagnosis and aggressive treatment are critical to improve the prognosis of those with PH, increased public and health care provider awareness of the signs and symptoms of PH is important. In FY 2004, CDC funded the Pulmonary Hypertension Association to create a DVD to educate physicians on the symptoms and diagnosis of PH. The initial target audience is clinicians who are most likely to receive referrals from primary care physicians – cardiologists, pulmonologists and rheumatologists. CDC is also exploring opportunities to work on collaborative studies and surveillance reports with the Pulmonary Hypertension Association and other partners such as the American Heart Association and the National Heart Lung and Blood Institute. In FY 2005, CDC will continue to work with the Pulmonary Hypertension Association to foster greater awareness of pulmonary hypertension.

Item

Prevention of Preterm Birth – The Committee encourages the CDC to expand research on the causes of preterm birth, the prevention of preterm delivery for women at risk and the social and environmental factors exacerbating higher rates of preterm delivery in African-American women. (Page 49)

Action taken or to be taken

Preterm delivery is the leading cause of hospitalization among pregnant women. It is the second leading cause of death among infants and the leading cause of death for African American infants. CDC is addressing the problem of preterm delivery through research and programs, focusing on both the social and biomedical factors that affect preterm risk. CDC formulates a prevention response by identifying populations at risk, assisting in implementation of prevention programs, and monitoring progress of prevention efforts.

In FY 2005, CDC will fund two to four extramural research projects for reproductive health research. Researchers will work to gain a better understanding of the susceptibility to preterm delivery, in a public health framework, through research that explores:

- The social, behavioral, community, genetic, historical, and biologic determinants of preterm birth.
- The effect of gene variation within and between groups on the risk of preterm birth, and how the environment modifies that risk.
- The potential to predict the risk of preterm birth using combinations of social, behavioral, community, genetic, historical, and biologic determinants of preterm birth.
- The development of a better understanding of the clinical use of 17-alpha hydroxyprogesterone for the prevention of preterm delivery; evaluation of barriers to its use; and development of capacity for future expanded studies of therapeutic effectiveness in the context of routine obstetrical care.

Item

School Health – The Committee urges the Centers for Disease Control and Prevention to prioritize abstinence education among adolescents served through the Divisions of Adolescent School Health [DASH]. Abstinence Education is consistent with the strategic direction of CDC in providing greater holistic health protection for young people and should be prioritized in activities funded through grants, cooperative agreements and other partnerships with DASH. (Page 49)

Action taken or to be taken

CDC recognizes that the only certain way to prevent HIV, sexually transmitted diseases, and unplanned pregnancy is to not engage in sexual intercourse. CDC is committed to helping to increase the percentage of young people who have chosen not to engage in intercourse.

CDC currently funds 48 states, seven territories and 18 large city education agencies to implement efforts to prevent HIV infection in young people. CDC encourages these agencies to focus on strategies to: (1) identify useful approaches to increase abstinence, and enable interested state and local agencies to implement these approaches; (2) enable interested organizations that focus only on increasing abstinence to work with organizations that focus on abstinence and increasing condom use among those sexual active; and (3) develop and implement approaches for maintaining partnerships to help young people to not engage in sexual intercourse. Twelve of these states (FL, LA, MI, MN, NC, NM, NV, RI, VA, WI, WY, and N. Mariana Islands) currently receive supplemental funding to specifically strengthen and expand existing efforts to help young people abstain from sexual intercourse.

In addition, CDC currently funds six national non-governmental organizations to develop strategies that focus on abstinence education to help young people to not engage in sexual intercourse.

Item

State Adolescent Health Coordinators Network – The Committee has learned of concerns that CDC decided not to continue funding the State Adolescent Health Coordinators Network (SAHCN) Annual Meeting. This meeting provides a focus on the unique needs and assets of the adolescent population, bringing together specific expertise on the health issues that face adolescents and on the special programmatic considerations for this population. The Committee urges CDC to consider renewing its support of this activity to promote adolescent health, providing that the meeting organizers provide the necessary assurances to be eligible for federal funding. (Page 49)

Action taken or to be taken

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

CDC recognizes the critical role played by the State Adolescent Health Coordinators in addressing the health needs of our nation's young people. CDC will continue to fund the State Adolescent Health Coordinators (SAHCN) Annual Meeting.

Item

Sleep Disorders – The Committee is concerned about the prevalence of sleep disorders and recognizes the need for enhanced public and professional awareness on sleep and sleep disorders. The Committee encourages CDC to work with other agencies, such as the National Center on Sleep Disorders Research (NIH), and voluntary health organizations, such as the National Sleep Foundation, to support the development of a sleep education and public awareness initiative. **(Page 49)**

Action taken or to be taken

According to research, one quarter of all Americans suffer from frequent sleeplessness, defined as insufficient sleep or rest for at least 14 of the last 30 days. Frequent sleeplessness is inversely related to age, being reported by 34% of younger adults. Notably, individuals reporting frequent sleeplessness are also significantly more likely to report fair or poor general health, frequent mental distress, frequent depressive and anxiety symptoms, and activity limitations. Health risk behaviors – such as smoking, physical inactivity, and obesity – are also significantly more prevalent among respondents reporting frequent sleeplessness. Thus, the prevalence of disturbed sleep and the gravity of its correlates suggest that sleep is an important area for public health assessment and intervention. CDC currently participates on the Sleep Disorders Research Advisory Board, housed within the National Heart Lung and Blood Institute at the NIH.

Item

Steps to a HealthierUS – The Committee commends CDC for its work on the Steps program, including its partnerships with national organizations, such as the YMCA, aimed at coordinating and delivering program models to additional communities across America, including rural and disadvantaged communities. In order to expand the reach and impact of the Steps program, the Committee urges the CDC to continue and increase funding for these national partnerships. **(Page 49)**

Action taken or to be taken

In FY 2004, CDC funded the YMCA for four-year Steps to a HealthierUS cooperative agreement grant to support the Steps Communities. The YMCA's strong presence in the community, with local chapters nationwide, provides an ideal opportunity to build strong partnerships and increase the capacity and impact of Steps communities. The Steps program will continue to work with the YMCA in FY 2005.

Item

Alpha-1 Antitrypsin Deficiency – The Committee encourages CDC to consider supporting an Alpha-1 screening and detection program that utilizes public and professional education regarding lung disease, both genetic and tobacco related. **(Page 50)**

Action taken or to be taken

CDC is not actively involved in public screening and detection for Alpha-1 Antitrypsin Deficiency. CDC supports new collaborative efforts between its National Center on Birth Defects and Developmental Disabilities and its Office of Genomics and Disease Prevention to address the public health needs related to this deficiency.

Item

Asthma – The Committee urges CDC to expand its outreach aimed at increasing public awareness of asthma control and prevention strategies, particularly among at-risk populations in underserved communities. To further facilitate this effort, CDC is urged to partner with voluntary health organizations, such as the American Lung Association to support program activity consistent with the CDC's efforts to fund community-based interventions that apply effective approaches demonstrated in research projects within the scientific and public health community **(Page 50)**

Action taken or to be taken

CDC is further expanding its outreach aimed at increasing public awareness of asthma control and prevention strategies, particularly among at-risk populations in underserved communities. This year, through its National Asthma Health Education Enhancement effort, CDC has funded voluntary health organizations such as the American Lung Association, the Allergy and Asthma Network/Mothers of Asthmatics, and the Asthma and Allergy Foundation of America to conduct activities related to asthma education. These activities range from identifying effective educational programs for adults that can be adapted for nationwide use to educating children with asthma and their families and caregivers. In addition, in 2005 CDC will announce a new Request for Application targeting voluntary health organizations and the underserved populations that they serve. CDC is also funding six national nongovernmental organizations, seven urban school districts, and one state education agency to implement strategies within a school-based environment to reduce asthma episodes and related school absences, especially among youth who are at highest risk. CDC has also created a Web site for state and local public health organizations (<http://www.cdc.gov/nceh/airpollution/asthma/interventions/interventions.htm>) and others called "Effective Interventions for Asthma Control" to provide information on "what works" as well as to provide access to materials that can be used to adapt and implement the interventions.

Item

Asthma - The Committee commends CDC's efforts to collect national and local data on the incidence and prevalence of asthma and to implement asthma prevention programs. The Committee encourages CDC to continue with these activities and expand its prevention programs into areas of high pediatric asthma incidence. **(Page 51)**

Action taken or to be taken

CDC has successfully added asthma prevalence questions to the Behavioral Risk Factor Surveillance Survey, the National Youth Risk Behavior Survey in 2003, and the state and city Youth Risk Behavior Survey in 2005. Asthma prevalence data will now be available to all 50 states, Washington DC, and 3 territories. CDC is also developing the National Asthma Survey (NAS) which is a comprehensive state/city level detailed asthma survey. In addition, CDC funds 35 state/city/territories to develop and implement asthma surveillance programs within their jurisdictions. The results of all of these programs are used to plan, implement, target, and evaluate intervention activities. CDC is also funding the Kaiser Foundation Research Institute and the Miami-Dade County Health Department to implement population-based asthma incidence surveillance programs.

Through CDC's extensive surveillance activities, areas of high pediatric asthma incidence are being identified. CDC currently funds 7 urban school districts and 1 state education agency to implement strategies to reduce asthma related illnesses. CDC also partners with a number of voluntary health organizations, including the American Lung Association and the Asthma and Allergy Foundation of American to conduct activities focused on asthma education. Some of these activities can be adapted for education of children with asthma and their families and caregivers. CDC will continue to support these efforts and will continue looking for ways to address areas of high pediatric asthma incidence.

Item

Lead Poisoning – Lead poisoning among Hispanic children in the nation is a significant problem. Oklahoma and Texas have a unique outreach program to the Hispanic community to help identify at-risk children and educate their parents about the source of the lead poisoning. The CDC is encouraged to work with the State Public Health Departments in Oklahoma and Texas to further develop this pilot program. **(Page 51)**

Action taken or to be taken

In FY 03, CDC awarded 3-year cooperative agreements to both the Oklahoma State Department of Health and Family Health Services and the Texas Department of State Health Services to support their unique lead poisoning outreach programs into Hispanic communities. These funds have enabled Oklahoma and Texas to operate a comprehensive lead program, including screening, case management, education and outreach, and data and surveillance. Using funding from CDC, Oklahoma used its screening plan to identify communities at high risk of childhood lead poisoning such as Hispanic communities and to tailor community intervention projects to meet the specific lead screening and education needs of those communities. Oklahoma also used their surveillance data to identify zip codes where the Hispanic population was determined to be at greatest risk in order to target resources. Texas has developed educational materials in both English and Spanish and many programs have Spanish-speaking outreach workers. Texas is using CDC funding to support several projects to address the health disparities of Hispanic children including a targeted education plan in El Paso for the parents in the Segundo Barrio, a high-risk community near the Mexican border and an old lead smelter; a partnership in Houston with Madre de Madres, a community-based organization to provide outreach to mothers in high-risk Hispanic neighborhoods; and routine outreach conducted in churches in Hispanic Neighborhoods in El Paso, Houston, Laredo, and San Antonio.

Item

Severe Combined Immune Deficiency – The Committee understands that scientists working in the intramural program at the NHGRI have developed the technology to screen newborns for severe combined immune deficiency disease (SCID) or “the bubble boy disease.” The Committee commends the CDC for the work begun on the development of a newborn screening program for SCID. Further, the Committee encourages the CDC to complete the development of the program and work in collaboration with relevant voluntary health organizations in developing a treatment protocol for any newborns that test positive for SCID. **(Page 52)**

Action taken or to be taken

CDC’s Environmental Health Laboratory would welcome the opportunity to develop a newborn screening program for SCID. CDC’s National Center on Birth Defects and Developmental Disabilities supports the idea that the newborn screening test for SCID developed at NHGRI appears promising and that pilot testing using a population-based sample is important to do in order to validate the test. The National Center on Birth Defects and Developmental Disabilities looks forward to providing technical consultation to the National Center on Environmental Health and NHGRI as they move forward with this proposed activity.

Item

Health Statistics – The Committee supports the efforts to strengthen health statistics programs. The Committee is aware that the data systems of the National Center for Health Statistics require additional investment in order to sustain ongoing operations as well as to make needed improvements in content and technology. The Committee recognizes that the data provided by the Center are important to the ability of the Congress to set health priorities, evaluate funding requests, and provide oversight to the performance of Federal health agencies. They are equally important to the day to day planning and management of health programs of CDC and to the biomedical research conducted by NIH. The Committee commends Secretary and Director for the increased request and encourages each to ensure that continued support of these data systems is provided and to make needed improvements in content and technology. **(Page 53)**

Action taken or to be taken

CDC will use the increased funding received in FY 2005 to maintain and improve its core data systems. Data derived from these systems support health policymaking in the Department and the health sector generally. Increased funding will allow CDC to take steps to: modernize the Nation’s vital statistics system; sustain the basic operations of the National Health and Nutrition Examination Survey; return surveys on healthcare providers to a more stable cycle; and redesign the sample for the National Health Interview Survey. These investments will help ensure that the highest quality and most timely data are available to support health programs and contribute to health policymaking.

Item

Domestic HIV/AIDS Prevention – The Committee applauds CDC’s steps to emphasize HIV testing to identify infected persons who are not aware of their own infection and to get them into treatment and prevention services. The Committee encourages the CDC to work specifically with federal programs providing reproductive health services to women to implement HIV/AIDS testing and counseling as a part of the Advancing HIV Prevention Initiative. **(Page 53)**

Action taken or to be taken

One of the four key strategies of CDC’s new initiative, “Advancing HIV Prevention (AHP): New Strategies for a Changing Epidemic,” announced April 2003 is to further decrease perinatal HIV transmission. The aim of this strategy is to focus on working with partners to promote routine, voluntary prenatal testing; develop guidance for using rapid tests during labor and delivery or post partum; provide training in conducting prenatal testing; and monitor integration of routine prenatal testing into medical practice. CDC is also recommending that clinicians routinely screen all pregnant women for HIV infection, using an “opt-out” approach.

Among the many activities CDC has undertaken to implement this initiative are key collaborations with other federal agencies. For example, in 2004, the Office of Populations Affairs (OPA), Department of Health and Human Services, funded 63 projects to expand the availability of on site HIV testing and counseling and HIV-related referral services in family planning and reproductive health programs. CDC has provided technical assistance to OPA and its grantees in incorporating the “Advancing HIV Prevention” strategies into OPA programs. CDC staff participated in OPA grantee meetings for the past two years to assist in incorporating HIV counseling and testing as part of routine care provided by OPA grantees.

CDC has worked with the Bureau of Primary Health Care (BPHC), HIV/AIDS (HAB) and Maternal and Child Health in the Health Resources Services Administration (HRSA) to ensure that all pregnant women are routinely tested for HIV

and, in areas of high HIV prevalence, to make HIV testing part of routine medical care for women of reproductive age who receive primary care services in HRSA-funded programs.

Item

Tuberculosis – The Committee urges CDC to work with the U.S. Citizenship and Immigration Services (USCIS) to develop novel TB screening strategies for individuals emigrating from high TB incidence countries. The Committee also encourages CDC to consider implementing screening programs for high-risk individuals residing in the U.S. for latent TB. (Page 54)

Action taken or to be taken

More than half of TB cases in the U.S. occur among people born outside this country, often in countries with a high burden of disease. CDC works on several fronts to address the problem of TB among the foreign-born.

For example, CDC collaborates with the Department of Homeland Security's Immigration and Customs Enforcement (ICE) agency to prevent interruption of TB treatment among infected detainees. Interruption of TB treatment is a major cause of concern in TB control. Patients who fail to receive treatment are at risk for developing multi-drug resistant tuberculosis (MDRTB), which presents more medical risk to the patient and is far more costly to treat. CDC approached the Division of Immigration Health Services, HRSA in 2002 to develop guidelines to prevent interruption of TB treatment among infected detainees who were released from ICE facilities. These guidelines formalize collaborations between state and local TB prevention programs, and immigration services and agencies to ensure continuity of care among TB patients who move between the United States and other countries.

Through these collaborations, ICE detainees with confirmed or suspected TB are enrolled in one of three programs: (1) The U.S.-Mexico Binational TB Referral and Case Management Project led by CDC; (2) CureTB (San Diego County Health Department, CA); and (3) TBNet (Migrant Clinicians Network). Increased notification of TB cases from ICE detention facilities and contract jails will facilitate continuity of care for a larger number of patients. To support this effort, local TB control program staff is encouraged to ascertain ICE custody status when following cases in local detention facilities.

In addition, overseas medical screening for TB is required of all immigrants and refugees applying to reside permanently in the United States. U.S. immigration regulations and CDC guidelines stipulate that immigrants and refugees applying for permanent residence in the United States must have a medical evaluation, including TB screening, when applying for a permanent resident visa. Designated overseas physicians (called panel physicians) screen applicants to ensure that they do not enter the United States with infectious TB. Candidates who have infectious TB are required to undergo treatment prior to immigration. Those who may have inactive TB are referred for further evaluation and possible treatment following immigration. In addition, CDC has recommended enhanced overseas medical screening for refugee populations that are at especially high risk for TB disease. In 2003-2004, the United States expanded TB diagnosis and treatment components for 8,000 U.S.-bound Liberian refugees in Cote d'Ivoire and 15,000 Laotian Hmong refugees in Thailand.

CDC also funds state and local TB control programs for the evaluation and treatment of patients with TB disease, evaluation and treatment of persons exposed to persons with TB disease (contacts), and evaluation and treatment of persons at high risk of TB disease and latent TB infection (LTBI). Contacts to infectious TB cases and immigrants are at very high risk of developing TB disease if they are infected, and are therefore a priority for screening and treatment. All of CDC's TB grantees are responsible for establishing programs to evaluate contacts and treat those with LTBI, and must meet specific performance measures related to the investigation and treatment of persons at high risk for LTBI.

Item

Tuberculosis – The Committee urges the CDC to continue its support for the TB vaccine research cooperative agreement in partnership with the leading private foundation conducting clinical field site trial work on TB vaccines. The Committee expects CDC will provide leadership and technical assistance on field site development and surveillance. (Page 55)

Action taken or to be taken

In September 2004, CDC awarded a three-year cooperative agreement to a private foundation conducting clinical field site trial work with funding for the first year at \$925,000. The specific aims of this cooperative agreement are to: (1) Create a professional development program in Clinical Research Practice for the full range of staff needed in a large, community-based TB vaccine trial; (2) Develop laboratory capacity for advanced TB diagnosis and immunologic assays, logistics and systems that will meet regulatory standards, and develop referral systems to treat and cure patients with TB as required for a TB vaccine trial; (3) Conduct epidemiologic studies to characterize TB incidence and prevalence, and to conduct observational cohort studies that will mimic the conduct of a vaccine trial;

and (4) Refine information on TB prevalence and incidence in neonatal and adolescent cohorts in the proposed vaccine trials site.

The foundation has identified a field site in southern Andhra Pradesh, India and is working with a group of investigators based at St. John's Medical College in Bangalore, India. The CDC project officer visited with foundation staff during the first quarter of the award to review plans and identify areas of collaboration and assistance. Protocols for the epidemiology studies have been developed and are under review, and studies are expected to begin in mid-2005. Assuming successful completion of cooperative agreement activities and meeting agreed upon milestones, funding is available in FY 2005 budget for this work.

Item

Tuberculosis – CDC is encouraged to work with the State of Oklahoma, and other states wishing to participate, to support these model programs aimed at preventing and controlling TB in the population. The CDC is also encouraged to work with the country of Mexico to help them eradicate this problem within their own country. (Page 55)

Action taken or to be taken

In Oklahoma, Catholic Charities works with the State of Oklahoma Refugee Health Program and local health departments to locate and refer refugees for screening for TB and other communicable diseases and health conditions. In addition to referrals, other services include transportation to doctors' offices and clinics, translation/interpretive services, and help in obtaining food, housing, jobs, and legal assistance.

CDC works closely with the World Health Organization (WHO), the Pan American Health Organization (PAHO), Mexico, the U.S.-Mexico Border Health Commission, and the four U.S. Border States of California, Arizona, New Mexico, and Texas to address this significant TB problem that exists in Mexico and along the border. One of the principle activities in which CDC is involved is the Binational Case Management and Referral System Project, also known as the Binational Card Project for TB. The Card contains 1-800 toll-free numbers for the U.S. and Mexico and other basic information about the patient's treatment. However, the patient's name does not appear on the card and neither does the word TB. This Project is the product of a close collaboration between CDC, the Mexico Ministry of Health, and U.S. and Mexican border state and migrant health partners. The goals are to: (1) Ensure continuity of care and completion of treatment; (2) Reduce TB and prevent drug resistance in both countries; (3) Coordinate referral of patients between health systems; and; (4) Provide a model for other settings and diseases.

The Project was launched in 2003 and by the end of 2004 had distributed almost 1500 Cards in Mexico and 500 in the U.S. Training activities have been conducted at all project sites, and posters, brochures, and a flipchart have been developed to educate patients and providers. Evaluation results are anticipated in 2005. This project represents the strong consensus for binational collaboration. Both countries' public health systems see this as a critical step to respond to identified TB needs in the region and to improve treatment outcomes. If the binational card program proves successful in the pilot sites, CDC's goal would be to extend it to all of the United States and Mexico, as well as to use it as a model for other diseases in this setting.

CDC also is involved in other border binational projects (3 in Texas/New Mexico, 3 in Arizona, and 2 in California), which were created in the 1990's in response to the national surge in TB cases and growing needs for TB surveillance, diagnosis, treatment, and prevention along the U.S.-Mexico border. In Texas, CDC assigns a public health advisor to coordinate TB activities for the 3 border projects. In California, CDC supports CURE-TB, operated by the San Diego County TB program and TB Net, operated by the Migrant Clinicians Network, to assist with referral, access to medical services, and the movement of patients across the border to improve the continuity of care for patients with TB disease or TB infection. Finally, CDC is actively assisting the Mexico National TB Program strengthen implementation of national TB control, including assistance with a national drug resistance survey and various operations research projects.

Item

Meningococcal Disease – The Committee is aware of recent CDC efforts to consider increasing information on meningococcal disease and ways to prevent it so that the general public will be better educated on the symptoms and prevention methods. The Committee recommends that CDC work to improve education and immunization programs and encourages the CDC to partner with the National Meningitis Association to ensure that all families, especially those with adolescents and young adults, are effectively educated on this disease, vaccine availability, and all methods of prevention. (Page 55)

Action taken or to be taken

To improve information about and awareness of meningococcal disease, CDC has added a chapter on meningococcal disease to its course syllabus/textbook *Epidemiology and Prevention of Vaccine-Preventable*

Diseases. More than 30,000 copies of this book have been distributed to providers throughout the U.S. In addition, a segment on meningococcal disease and vaccine was added to the 2004 edition of the CDC satellite broadcast series of Epidemiology and Prevention of Vaccine-Preventable Diseases. This content will be included in future broadcasts of this training series. Meningococcal vaccine (including the new conjugate vaccine) is part of the standard content of Immunization Update-type presentations delivered by CDC training staff. We have also provided the National Foundation for Infectious Diseases presentations for their meningococcal information/educational efforts for the medical community.

Furthermore, on September 23-24, 2004, CDC conducted a two-day meeting of Meningococcal Disease Education Stakeholders' in Atlanta. The purpose of the meeting was to define the purpose, objectives, and primary audiences for an educational campaign, identify campaign needs and strategy options. The meeting included representatives from medical and public health professional associations, academia, local and state public health officials, other federal agencies, groups that have conducted similar campaigns on other diseases, representatives from other countries that have implemented similar campaigns on meningococcal disease, pharmaceutical companies, and non-profit, patient advocacy groups. Representatives of the National Meningococcal Association participated in the meeting. Efforts are also underway to enhance states' ability to detect and classify meningococcal cases by serogroup cases.

Item

Research funding – The Committee urges the CDC to reexamine the restrictions placed on external researchers so that these researchers may be able to validate the internal researcher's findings. The Committee recognizes that validating research findings requires that external researchers also have access to original datasets, not simply final datasets, and it directs that the CDC make such datasets available to external researchers in such a way as to assure compliance with the privacy protections set forth in Title 45, Part 46, and Code of Federal Regulations. **(Page 55/56)**

Action taken or to be taken

CDC believes that public health and scientific advancement are best served when data are released to, or shared with, other public health agencies, academic researchers and appropriate private researchers in an open, timely, and appropriate way. CDC also recognizes the need to maintain high standards for data quality, the need for procedures that ensure that the privacy of individuals who provide personal information is not jeopardized, and the need to protect information relevant to national security, criminal investigations, or misconduct inquiries and investigations. The purpose of CDC's Data Release/Sharing Policy is to ensure that (1) CDC routinely provides data to its partners for appropriate public health purposes and (2) that all data are released and/or shared as soon as feasible without compromising privacy concerns, federal and state confidentiality concerns, proprietary interests, national security interests, or law enforcement activities. The application of this policy to any specific data set needs to be done carefully and with attention to any conditions or restrictions that were placed on the data release when the data were provided to CDC by another entity. All released data must be as complete and accurate as possible and evaluation of data quality must include tests for completeness, validity, reliability, and reproducibility.

Item

Antimicrobial Resistance – The Committee encourages the CDC to expand support for training and education of medical and public health personnel related to antimicrobial resistance and public health emergencies, including training laboratory personnel in the recognition of resistance in pathogens. **(Page 56)**

Action taken or to be taken

CDC expanded support for training and education of medical and public health personnel related to antimicrobial resistance by:

- Creating a medical student curriculum promoting appropriate use of antibiotics. A final version of the curriculum is scheduled to be released for implementation in 25 medical schools. In 2006, the curriculum will be implemented nationally.
- Creating curricula for pediatric and family practice residents focusing on the diagnosis and treatment of ear infections, a frequent reason for antibiotic prescribing.
- Funding state-based multifaceted interventions for clinicians and patients to promote the appropriate use of antibiotics for outpatient upper respiratory infections ("Get Smart: Know When Antibiotics Work").
- Developing and disseminating culturally specific materials on appropriate antibiotic use among healthcare providers and institutions serving Spanish speaking populations and developing materials for American Indian populations.

CDC expanded support for training and education of laboratory personnel by:

- Developing Clinical and Laboratory Standards Institute (formerly National Committee for Clinical Laboratory Standards) guidelines for clinical microbiology laboratories for compiling and reporting summaries of cumulative antimicrobial susceptibility data to aid in clinical decisions (i.e., improving patient safety by reducing medical errors).
- Supporting projects to promote linkages and coordination between State Public Health and clinical microbiology laboratories to optimize laboratory practice, in collaboration with medical societies and other stakeholders.
- Creating a website entitled Multi-level Antimicrobial Susceptibility Testing Educational Resources (M.A.S.T.E.R.) which has periodic updates and case studies addressing contemporary antimicrobial susceptibility testing issues, questions and answers for users, a review of recent papers that have implications for testing and reporting, other new information, and lists of reference materials including books, and links to other websites.
- Teaching antimicrobial susceptibility testing and reporting through the National Laboratory Training Network (NLTN). The NLTN presented 48 courses for more than 12,000 participants between January 1, 2003, and April 30, 2004. The focus of these courses was the importance of using NCCLS standards for testing and insuring that reports given to clinicians provide correct information for appropriate treatment.

Item

Chronic Fatigue Syndrome (CFS) – The Committee is pleased that CDC is restoring funds for CFS research and that these funds are being used in substantive areas. The Committee encourages CDC to continue the establishment of a national registry to examine such things as: studies of etiologic agents, diagnostic markers, natural history, and risk factors using specialized molecular epidemiology techniques and advanced surveillance methodologies. (Page 56)

Action taken or to be taken

CDC has extended the CFS program payback period through FY 2005 to facilitate the expanded CFS research plan.

In FY 2004, CDC developed three possible designs for a pilot regional CFS Registry. A pilot registry is a necessary first step before beginning a full-scale national registry. In FY 2005, CDC awarded a contract to assess the 3 registry designs for efficacy and efficiency in identifying large numbers of patients with CFS. Assessment of these designs will be completed in mid FY 2005 and CDC plans to implement the pilot registry in Georgia this fiscal year. CDC selected Georgia for the pilot registry because it will be possible to compare data with that from an ongoing population-based surveillance study (see below) in defined metropolitan, urban and rural populations.

In addition to the registry, CDC's CFS research program uses advanced surveillance methodologies combined with specialized molecular epidemiology techniques to identify risk factors, etiologic agents, and diagnostic markers that can be used in control and prevention programs for CFS. As part of its expanded CFS research agenda, CDC will carry out studies in a variety of substantive areas, in addition to the pilot registry, during FY 2005:

- Publish results on autonomic nervous system dysfunction, sleep pathology, cognitive function, neuroendocrinology, immune status, and psychopathology from a clinical evaluation study of 227 subjects with CFS and other fatiguing illness identified from the general population of Wichita, Kansas.
- Publish results from specialized molecular epidemiology studies to identify diagnostic markers for CFS.
- Publish results, from collaborative studies with two academic institutions, concerning physiologic mechanisms and the natural history of CFS.
- Finish the first year of surveillance for CFS in various racial/ethnic groups of urban and rural populations in Georgia.
- Begin the second year of surveillance to define the incidence of CFS in Georgia and better define the economic impact of the illness and patients' access to health care.
- Begin an in-hospital research study, using specialized molecular epidemiology techniques, of people identified with CFS from the Georgia surveillance study, to identify risk factors and diagnostic markers for CFS.
- Continue to support cooperative agreements with two academic institutions to further understand physiologic mechanisms and the natural history of CFS and identify diagnostic markers.

- Sponsor a workshop -- CFS Computational Challenge -- to describe the pathophysiology of CFS and identify markers that can be used in the diagnosis and treatment of the illness.

Item

Hepatitis – The Committee encourages CDC fully implement the National Hepatitis C Prevention Strategy. This prevention strategy includes enhancing state and local health department and community-based organizations' efforts to provide counseling, testing, partner notification, health education and medical referral to persons at risk of or infected with hepatitis C, and to enable state health departments to establish surveillance systems to monitor the burden of disease. While most States have designated a state Hepatitis C Coordinator, the Committee is concerned that coordinators are still lacking in six states. CDC is urged to work with these States to ensure the availability of hepatitis C coordinators. The Committee also notes that hepatitis C counseling and testing programs are not universally available, and encourages that CDC address this gap. Further, the Committee is concerned about reports that the CDC may reduce the number of Hepatitis C prevention demonstration project sites from 15 to 5 in FY 2005 and urges the Director to continue support for all 15 sites. The Committee also encourages more aggressive HCV outreach linkages to care are available in all states to those seeking hepatitis C prevention services. Finally, the Committee is pleased that several States, in collaboration with community stakeholders, have developed State plans to address hepatitis, but understand that funding has not been made available to implement these plans. Funds have been included above the request to support and expand the abovementioned hepatitis C activities. In addition, the Committee is concerned with increasing rates of adult infection with hepatitis A and B, and urges that the CDC consider launching an expanded vaccination program in response to this health issue. **(Page 57)**

Action taken or to be taken

The resources available to CDC's hepatitis program have been used to assist the states with their hepatitis prevention efforts in a number of ways. First and foremost, CDC has provided funding for Hepatitis C Coordinators. Forty eight states and 3 large metropolitan areas receive such support. As the Committee notes, hepatitis C counseling and testing programs are not universally available. In fact, a survey by the National Association of County and City Health Officials (NACCHO) several years ago found that fewer than 50% of city and county health departments provided hepatitis C counseling and only 22% provided HCV testing.

The Hepatitis C Coordinators have helped to lead state efforts to implement the integration of hepatitis prevention services into existing public health programs. Those efforts have relied in large part on "best practices" developed through the Viral Hepatitis Integration Project (VHIP) demonstration sites. The reduction in the number of such demonstration sites in the new project funding cycle that began in 2004 was in order to preserve resources for other prevention activities, such as the Hepatitis C Coordinator positions, sentinel surveillance, the development of educational and training materials, and support for the development of state hepatitis prevention plans. Regarding linkages to care for individuals infected with HCV, a number of states have made Ryan White CARE funds available for the treatment of individuals co-infected with HIV and HCV; there is no comparable funding source for individuals infected with HCV only. CDC is not aware of any additional funds that have been made available to support and expand the above-noted hepatitis C prevention and care activities.

Item

Lyme Disease – The Committee continues to be concerned about the increase in tick-borne illnesses, including Lyme disease and Southern Tick-Associated Rash Illnesses. The Committee urges the Director, in collaboration with other relevant Departmental Operating Divisions, to consider the establishment of a comprehensive, multi-agency, five-year plan that lays out a blueprint for making progress toward effective surveillance, prevention, and control of tick-borne illnesses. **(Page 57)**

Action taken or to be taken

CDC's Lyme disease prevention and control activity is a science-based program of education, research, and service that currently partners with federal agencies including the Food and Drug Administration and the National Institutes of Health, state and local health departments, academic institutions, and community-based organizations. CDC will continue its efforts in conjunction with these partners to establish a multi-year, comprehensive approach to more effectively prevent and control Lyme disease and other tick-borne infections including Southern Tick-Associated Rash Illness, and to promote appropriate surveillance for these conditions. CDC's program emphasizes the goal of working with Lyme disease endemic communities to develop an Integrated Pest Management (IPM) approach which includes a wide assortment of practical tick control strategies. IPM employs environmental management, biological and chemical control of ticks, and enhanced personal protection through tick avoidance and other measures to prevent Lyme disease.

Item

Sepsis – The Committee understands that sepsis remains a leading cause of death, in part because too few medical personnel know how to diagnose and treat it properly. The Committee encourages the CDC to work with State health departments to expand surveillance efforts related to sepsis. Furthermore, the Committee encourages the CDC work with relevant voluntary health organizations to examine effective means of educating infectious disease physicians, emergency room doctors, and critical care nurses, especially those in rural and traditionally underserved areas, in use of the new guidelines to identify sepsis and improve patient outcomes. **(Page 57)**

Action taken or to be taken

CDC has implemented several interventions to prevent bloodstream infections, including educating clinicians on the appropriate use of intravenous catheters and other strategies to prevent infections that lead to sepsis, as well as measuring and providing feedback information to clinicians on rates of bloodstream infections.

- A collaborative project with healthcare providers and sponsoring organizations in Southwestern Pennsylvania (Pittsburgh Regional Healthcare Initiative) has resulted in a 55% region-wide decline in bloodstream infections.
- Bloodstream infection rates were reduced by over 18% overall in the 13 CDC-funded Prevention Epicenters that participated in an educational intervention to bloodstream infections.
- CDC developed the Campaign to Prevent Antimicrobial Resistance in Healthcare Settings that centers on four main strategies: preventing infection, diagnosing and treating infection, using antimicrobials wisely, and preventing transmission. The Campaign has been expanded to reach non-infectious disease clinicians, including hospitalists, surgeons, nephrologists, and gerontologists.
- In collaboration with the Society of Hospital Medicine, CDC has begun developing a quality improvement program targeted to hospitalists, aimed to reduce antimicrobial resistance and hospital-associated infections. The first workshop was held in April 2004, and the materials for the workshop and the toolkit are being revised based on the course evaluations. The initial focus of the program is the reduction of bloodstream infections due to antimicrobial resistant bacteria.

Item

West Nile Virus - The Committee supports the CDC's efforts to complete a national plan for West Nile virus response, including surveillance, prevention, and control of the virus nationwide. The Committee is aware of concerns that political subdivisions of states, such as local and county/parish governments have not had the necessary resources to combat outbreaks, even though they have a significant responsibility for response. The Committee urges the Director to factor in the needs of local governments in the allocation of West Nile response funds in FY 2005. **(Page 57/58)**

Action taken or to be taken

Through the Epidemiology and Lab Capacity Grant, CDC provides funding for all states, some large cities/counties, and Puerto Rico to assist in the development of comprehensive, long-term West Nile virus (WNV) surveillance, prevention, and disease control programs. CDC has encouraged states to factor in the needs of local governments in the allocation of WNV funds. State health departments in turn negotiate with local and county/parish governments to determine their funding needs for WNV surveillance, control and prevention activities.

Item

Gun Control Advocacy – The Committee recommendation maintains language carried in the fiscal year 2004 bill and prior years prohibiting federal funds from being used to lobby for or against the passage of specific federal, state or local legislation intended to advocate or promote gun control. The Committee understands that the CDC's responsibility in this area is primarily data collection and the dissemination of that information and expects that research in this area to be objective and grants to be awarded through an impartial, scientific peer review process. The Committee requests that the Director be prepared to report on the steps taken to ensure this restriction is followed during the FY2006 budget hearings. **(Page 58)**

Action taken or to be taken

CDC takes this language seriously and continues to ensure that the agency and its grantees abide by this restriction. Dr. Gerberding will be prepared to discuss the agency's actions to ensure the restriction is being followed during the budget hearing this spring.

Item

National Violent Death Reporting System – The Committee is pleased with the progress that has been made towards implementation of a system of more timely, complete, objective and accurate information about violent deaths and injuries. The Committee encourages CDC to continue to work with both state and private partners in its implementation of this model plan. **(Page 58)**

Action taken or to be taken

Established by the CDC in Fiscal Year 2002, the National Violent Death Reporting System (NVDRS) allows states and communities to develop a system to collect timely, complete, and accurate information about violent deaths through the linkages of information from law enforcement agencies, medical examiners and coroners, health providers, crime laboratories, and other agencies. As of January 2005, CDC is funding 17 states to implement NVDRS. Through a national violent death reporting system, states can quickly see how their problems compare with others across the nation. Information from this system will help develop, inform, and evaluate violence prevention strategies at both state and national levels. CDC continues to work with state health departments, academic institutions, health care providers, national organizations, and others regarding the system's development and implementation.

Item

Cooperative Agreements – The Committee is concerned that CDC is considering altering the cooperative agreement that has effectively supported research, fellowships, training, preparedness and other activities at schools of public health over the past 23 years. The Schools of Public Health are an integral part of the public health infrastructure through preparation of future public health leaders and through key research and training activities. The Committee notes that the competitive, peer-reviewed projects funded through this mechanism are results-oriented and have positive evaluations. The Committee is aware that this cooperative agreement was one of the first such funding models at CDC that allow flexibility to meet unanticipated public health needs at the community level and rapidly respond to emerging situations while ensuring accountability and integrity. The Committee expects that CDC will not proceed with any modification to this arrangement without prior justification and consultation with the Committee. **(Page 60/61)**

Action taken or to be taken

CDC supports public health projects funded through the prior cooperative agreements and is not considering altering the mechanism by which CDC has conducted business with the Association of Schools of Public Health (ASPH), the Association of Teachers of Preventive Medicine (ATPM), and the American Association of Medical Colleges (AAMC). Instead, CDC will be conducting business as usual with the Academic Partner Associations thereby maintaining the input relationships with these Associations. Additionally, CDC is aware of the importance regarding preparation of future public health leaders through training activities developed by the Schools of Public Health and other academic partner associations. To ensure there is no disruption in training activities during the current cooperative agreement extension period completing at the end of FY 2005 and the anticipated award of new cooperative agreements, CDC has also developed an additional announcement targeting the training activities. Award of this announcement to the Academic Associations will ensure there is no break or delay in funding support for the training programs, there will be no disruption in training cycle for the Fellowship and Traineeship activities, and will carry the training activities beyond the term of the current cooperative agreements that will complete at the end of this fiscal year. Ensuring the continuation of training activities will ensure the flow of trained Public Health Scientists into the public health workforce. For additional information regarding accomplishments and current activities please referred to the Terrorism Narrative Justification.

Item

Poison Control Centers – For many years the Committee has recognized the importance of the national network of poison control centers in the early identification of potential public health incidents and domestic terrorist events. The centers, which operate around the clock, have developed a national, real-time data collection, analysis and surveillance capability. The Committee urges the CDC to continue to incorporate these unique capabilities and to provide sufficient support to enable the centers to participate fully in the BioSense program as it develops. **(Page 61)**

Action taken or to be taken

Since 2002 CDC has collaborated with the American Association of Poison Control Centers (AAPCC) in developing statistical methods for centralized, real-time review of data from 62 of the 63 U.S. poison centers. Abnormalities generated from comparison to established historical baselines trigger an automated electronic alert which is then reviewed multiple times daily by AAPCC personnel, CDC medical toxicologists and epidemiologists. In the past year several regional centers have opted to use the same aberration detection software to review their own data. Multiple

events were successfully identified through this system including a major weapons-of-mass-destruction exercise (TOPOFF), an arsenic mass poisoning in Maine, and multiple other local clusters of chemical-associated illness. The primary goals of the CDC/AAPCC collaborative program continue to be early detection of a potential chemical associated public health threat, including chemical terrorism; enhancing support for local poison centers; and enhancing communication between poison centers and their respective health departments. In 2005, NCEH/ATSDR will work with the BioSense program to integrate data from the national network of poison control centers. The project to be funded in 2005 will to negotiate a signed license agreement with the AAPCC giving CDC direct access to the Toxic Exposure Surveillance system (TESS) database, exploring geographic information system (GIS) capabilities of using this technology in the Director's Emergency Operations Center, training staff to interpret the results, forcing mock events to test the system, and further evaluation of the system performance. Specific areas of evaluation include sensitivity of aberrancy detection, syndrome case definitions, data coding, and timeliness of reporting and statistical methods. The resources for this project will be provided through a cooperative agreement to the AAPCC.

Item

Physician Contact Database – The Committee understands the urgent need to contact, inform and mobilize physicians in public health emergencies and with threats of bioterrorism. The Committee is also aware that CDC is in discussions with the Federation of State Medical Boards to develop an automated data system of physician contact information to be used for these purposes. Within the funding provided, the Committee encourages the Secretary to initiate a pilot project in five states. The Committee requests that the Secretary be prepared to report on plans for the project during the hearings on the FY 2006 budget request. **(Page 150)**

Action taken or to be taken

CDC is developing a pilot physician directory protocol that will enable physician contact information to be incorporated into Health Alert Network (HAN) systems at state and city health departments. Our collaborating partner, the Federation of State Medical Boards, is establishing national standards for state medical boards to obtain, manage, and share physician contact information and to facilitate implementation of data gathering in five pilot states. CDC is ensuring that these standards mesh with the directory and alerting standards being established for public health departments as part of the Public Health Information Network (PHIN) and to test the use of this data in systems. CDC is working to establish mechanisms to assure the ongoing maintenance and management of physician contact data and its secure, appropriate and timely distribution among public health departments as required during health emergencies. Public Law (PL) 107-188, the Public Health Security and Bioterrorism Preparedness and Response Act of 2002, directs HHS to develop an Emergency System for Advance Registration of Volunteer Healthcare Professionals (ESAR-VHP). Within HHS, HRSA was delegated the responsibility for assisting States and Territories in establishing a standardized, volunteer registration system for its healthcare professionals. Activities to date include the creation of ESAR-VHP Technical and Policy Guidelines, Standards and Definitions guidance, and providing additional supplemental grant funding and technical assistance to States and Territories. When fully operational, ESAR-VHP will include readily available, verifiable, up-to-date information on the identity, licensing, credentialing, accreditation, and privileging of healthcare volunteers in hospitals and other healthcare facilities. Creation of ESAR-VHP provides the ability to pre-identify and contact volunteer healthcare professional to support emergencies and disasters across state lines and around the country. While the second (ESAR-VP) program may certainly be a sub-set of those health care professionals who are registered with the Federation of State Medical Boards, the purpose of the two systems are very different. The FSMB project is to develop public health directories for the sharing of critical information to the health care community, and the ESAR-VP is an active registry of those individuals who will be called on in an emergency to provide auxiliary health care to those in need.

EXHIBIT K. SIGNIFICANT ITEMS IN COMMITTEE REPORTS-SENATE

**SIGNIFICANT ITEMS FOR INCLUSION IN
THE FY 2006 CONGRESSIONAL JUSTIFICATION
AND OPENING STATEMENTS
SENATE REPORT NO. 108-345
CENTERS FOR DISEASE CONTROL AND PREVENTION**

Item

Chronic Fatigue Syndrome (CFS) – The Committee commends the CDC for building the leading CFS program in the Nation, supporting crucial population studies, clinical and laboratory research and education. The Committee directs CDC to provide sufficient resources to maintain the high caliber of this program. The Committee is very interested in CDC efforts to document the economic impact of the illness, to identify biomarkers using genomic and proteomics technology and to address health care providers' inability to appropriately diagnose and treat CFS. Further, the Committee encourages CDC to better inform the public about this condition, its severity and magnitude and to use heightened awareness to create a registry of CFS patients to aid research in this field. (Page 65/66)

Action taken or to be taken

In FY 2005, CDC awarded a three-year contract for a nation-wide CFS public awareness campaign. The objective of the campaign is to increase early diagnosis and treatment of CFS (i.e., decrease morbidity) by better informing the public about the illness. CDC CFS research program investigators have worked with CDC health communications experts and the contractor to develop details of the campaign, which will be launched in FY 2005.

In FY 2004, CDC developed 3 designs for a pilot regional CFS Registry, a necessary first step before beginning a full-scale national registry. In FY 2005, CDC awarded a contract to assess the 3 designs. CDC plans to implement the pilot registry in Georgia this fiscal year. CDC selected Georgia for the pilot registry because it will be possible to compare data with that from an ongoing population-based surveillance study (see below) in defined metropolitan, urban and rural populations.

In addition to the public awareness campaign and registry, CDC's CFS research program has published a preliminary estimate of the economic impact of CFS (in 2004) and is evaluating this in more detail, conducts an active program to identify biomarkers using genomic and proteomics technology, and supports a health care provider education activity. In 2005, CDC will:

- Continue the third year of a contract to educate physicians, physician assistants, nurse practitioners, and rehabilitation specialists about the detection, diagnosis, and management of CFS. In FY 2005, CDC will support a health communications evaluation expert to evaluate the effectiveness of the program to date.
- Finish the first year of surveillance for CFS in Georgia. In addition to measuring prevalence of CFS in the population, the study collects data on the economic impact of CFS and CDC will support a health economics fellow to analyze the data and plan further studies. The study also collects data on the access to health care for CFS by racial/ethnic minorities and CDC will initiate collaboration with Morehouse Medical School in this area.
- Begin the second year of surveillance to define the incidence of CFS in Georgia and better define the economic impact of the illness and patients' access to health care.
- Begin an in-hospital research study that uses genomic and proteomics technology in conjunction with advanced imaging techniques to identify biomarkers for CFS.
- Continue collaboration with the Defense Advanced Research Projects Agency (DARPA) Bio-Computation Program using genomics and proteomics data to identify CFS pathophysiology.
- Sponsor a workshop, entitled: "CFS Computational Challenge." Participants in the workshop will use genomics and proteomics data from a CDC in-hospital study of 227 subjects to describe the pathophysiology of CFS and identify markers that can be used in the diagnosis and treatment of the illness

Item

Hepatitis C – The Committee is concerned that the CDC has reduced the number of hepatitis C prevention demonstration project sites from 15 sites to only 5 sites in fiscal year 2005. The Committee urges CDC to reconsider

the closing of these 10 sites, and encourages CDC to begin implementation of a National Hepatitis C Prevention and Control program. **(Page 66)**

Action taken or to be taken

As the Committee notes, the number of Viral Hepatitis Integration Project (VHIP) demonstration sites was reduced in the new project funding cycle that began in 2004; that action was taken in order to preserve resources for other prevention programs, such as the Hepatitis C Coordinator positions, sentinel surveillance, the development of educational and training materials, and support for the development of state hepatitis prevention plans. CDC has provided funding for Hepatitis C Coordinators to all states that have applied for it. Currently, 48 states and 3 large metropolitan areas receive such support. The Hepatitis C Coordinators have helped to lead state efforts to implement the integration of hepatitis prevention services into existing public health programs.

Item

Hepatitis – The Committee is concerned that more than 75 percent of the 4 million HCV positive individuals are unaware of their condition and therefore urges a campaign of public announcements to urge appropriate screening and medical follow up of target populations. The Committee urges the expansion of cooperative agreement programs with national voluntary health organizations to meet this and other public health goals of CDC's Division of Viral Hepatitis. Finally the Committee is concerned with increasing rates of adult infection with hepatitis A and B, and urges that an expanded vaccination program be launched in response to this health issue. **(Page 66)**

Action taken or to be taken

CDC continues to develop and distribute educational materials for patients and training for physicians and other health professionals in both the private and public sectors. A recent example is the "Physicians Toolkit" of educational and training materials that was mailed to the offices of 150,000 primary care providers. CDC also has cooperative agreements with 12 organizations to develop, evaluate, and distribute such materials. Finally, CDC continues to work with the National Viral Hepatitis Roundtable, whose more than 110 member organizations include those devoted to health care professionals, voluntary health, and patient advocacy. Many of those groups have developed educational materials and campaigns that can be coordinated through the Roundtable for increased effectiveness and impact.

Item

Hepatitis - The Committee continues to be concerned about the prevalence of hepatitis and urges CDC to work with voluntary organizations and professional societies to promote liver wellness with increased attention toward education and prevention. In addition, the CDC is urged to continue to support the activities of the National Viral Hepatitis Roundtable. **(Page 66)**

Action taken or to be taken

CDC continues to develop and distribute educational materials for patients and training for physicians and other health professionals in both the private and public sectors. CDC also continues to work with the National Viral Hepatitis Roundtable, which plans to hold its second national meeting in Washington, DC, early in 2005.

Item

Patient Safety – The Committee also encourages the CDC to enhance the capacity for detection and response to medical errors and other adverse healthcare events at state and local levels through active monitoring, improved epidemiologic/root cause investigation, and onsite intervention to promote patient safety and improve patient outcomes. These efforts will enable the CDC to promote research on preventing medical errors and adverse healthcare events through feedback on adverse outcomes. **(Page 66)**

Action taken or to be taken

CDC developed the system and software for the National Healthcare Safety Network (NHSN), a web-based system to monitor infections and other adverse health events and to motivate local interventions. Deployment of NHSN version 1.0 is scheduled for early 2005. This national network represents the integration of three other systems, and its web-based platform allows it to be readily extended to include non-infectious adverse events and to allow reporting from any health care delivery setting. This system will enable infection control and other occupational health staff to have surveillance data and other healthcare safety resources at their fingertips.

CDC collaborated with healthcare providers in Chicago in demonstration projects showing the feasibility and utility of improved information systems and targeted educational interventions to increase adherence to hand hygiene, improve antimicrobial use, and reduce antimicrobial resistance in healthcare facilities. One of the many projects

successfully completed as part of this program involved developing and testing the electronic capture of pharmacy and laboratory data in surveillance for inappropriate antimicrobial use, as well as detection of hospital-acquired infections. Interventions were successful in discontinuing unnecessarily-prolonged vancomycin use in over half the cases and discontinuing redundant agents in 98% of cases. Educational sessions on hand hygiene resulted in increased hand hygiene compliance. The improvement in hand hygiene practices and decrease in inappropriate use of antimicrobials were associated with a decrease in infections caused by antimicrobial-resistant bacteria.

The Computer-assisted Antimicrobial Review to Optimize Therapy (CAROT) Project is a new project that will utilize an electronic data warehouse for the detection and remediation of redundant antimicrobial prescribing, unnecessary vancomycin use, and other prescribing errors. The recurrence of these errors and patient complications related to these errors will be measured. Interventions will include provision of treatment guidelines at the time of ordering antimicrobials, intensive education of providers, and just-in-time provider feedback based on real-time surveillance of errors by clinical pharmacist.

Item

HIV/AIDS Prevention – The Committee is concerned by the high rates of HIV infection among young men who have sex with men in the United States. Data recently reported at the International AIDS Conference in Barcelona indicate that infection rates are nine times higher for gay men than for women and heterosexual men and that African Americans and Latinos are at particularly high risk. The Committee urges the CDC to develop and implement new approaches to reach young men with life-saving HIV prevention services. **(Page 67)**

Action taken or to be taken

CDC has initiated and implemented specific HIV prevention activities that target men who have sex with men (MSM) of color. Activities range from epidemiologic studies to program evaluation. For example, CDC is supporting an epidemiologic study entitled “Brothers y Hermanos.” This study seeks to understand the cultural, social, psychologic, and behavioral factors that increase the risk for HIV infection in African-American and Latino MSM, as well as the risk-protective factors. It is being conducted in Los Angeles (Latino site), Philadelphia (African-American site), and New York City (African-American and Latino site). The study began September 2002 and is scheduled to end September 2005.

Another study, “African-American and Latino MSM Internet Study” aims to characterize the Internet sex-seeking behaviors of 500 African-American and 500 Latino MSM. An online epidemiologic survey will be constructed and respondents will be recruited from chat rooms and popular African-American or Latino MSM Internet sites. Emphasis will be placed on recruiting gay and non-gay-identified MSM. The study began September 2003 and is scheduled to end September 2005.

CDC is also supporting a program for 27 community-based organizations (CBOs) serving young men who have sex with men. The CBOs are required to conduct at least one of the following interventions: HIV counseling, testing, and referral services; health education and risk reduction; or outreach activities. Some CBOs were also funded to bring together organizations to implement linked networks of services for YMSM. CDC is conducting an evaluation of this initiative using multiple methods including program assessments, and process and outcome evaluations.

Item

Tuberculosis (TB) - The Committee encourages CDC to consider implementing screening programs for high-risk individuals residing in the United States for latent TB. The Committee also encourages the CDC to expand efforts to reduce racial disparities in TB incidence in the Southeastern United States. African-Americans in the Southeast bear a disproportionate burden of TB. **(Page 68)**

Action taken or to be taken

CDC funds state and local TB control programs for the evaluation and treatment of patients with TB disease, evaluation and treatment of persons exposed to persons with TB disease (contacts), and evaluation and treatment of persons at high risk of TB disease and latent TB infection (LTBI). Contacts to infectious TB cases and immigrants are at very high risk of developing TB disease if they are infected, and are therefore a priority for screening and treatment. All of CDC’s TB grantees are responsible for establishing programs to evaluate contacts and treat those with LTBI, and must meet specific performance measures related to the investigation and treatment of persons at high risk for LTBI.

In 2003, CDC and the Advisory Council for the Elimination of Tuberculosis (ACET) cosponsored a consultation with national, nongovernmental organizations and agencies whose programs could have an impact on TB control efforts among African Americans. The consultation was intended to raise awareness about this health disparity, solicit support for eliminating TB in the African American population, and develop recommendations for accelerating the

decline in TB rates among African Americans and resulted in a five point strategy, which included the call for increased research in this population.

CDC is now conducting formative research and intervention study entitled "Addressing Tuberculosis among African Americans in the Southeast." Study objectives are to: (1) Determine barriers to health-seeking behavior and treatment adherence for African American, non-Hispanic persons with or at risk for TB; (2) Determine barriers to TB guideline adherence among providers who serve this population; (3) Develop and test interventions to overcome identified barriers; and (4) Improve partnerships and collaboration among the TB programs and the providers and organizations serving this population. Protocol and instrument development is underway, and data collection is scheduled to begin in spring 2005. To keep all partners up to date on progress in addressing TB among African Americans, a quarterly newsletter highlighting TB issues in the African American population and progress on projects is being distributed nationally to public health and community partners who serve this community. The newsletter, TB Challenge, is also available on the Internet: http://www.cdc.gov/nchstp/tb/TB_Challenge/toc.htm.

Item

Tuberculosis – The Committee encourages the CDC to continue the TB vaccine research cooperative agreement in partnership with the leading private foundation conducting clinical field site trial work on TB vaccines. The Committee encourages CDC to provide leadership and technical assistance on field site development and surveillance. **(Page 68)**

Action taken or to be taken

In September 2004, CDC awarded a three-year cooperative agreement to a private foundation conducting clinical field site trial work. The specific aims of this cooperative agreement are to: (1) Create a professional development program in Clinical Research Practice for the full range of staff needed in a large, community-based TB vaccine trial; (2) Develop laboratory capacity for advanced TB diagnosis and immunologic assays, logistics and systems that will meet regulatory standards, and develop referral systems to treat and cure patients with TB as required for a TB vaccine trial; (3) Conduct epidemiologic studies to characterize TB incidence and prevalence, and to conduct observational cohort studies that will mimic the conduct of a vaccine trial; and (4) Refine information on TB prevalence and incidence in neonatal and adolescent cohorts in the proposed vaccine trials site.

The foundation has identified a field site in southern Andhra Pradesh, India and is working with a group of investigators based at St. John's Medical College in Bangalore, India. The CDC project officer visited with foundation staff during the first quarter of the award to review plans and identify areas of collaboration and assistance. Protocols for the epidemiology studies have been developed and are under review, and studies are expected to begin in mid-2005. Assuming successful completion of cooperative agreement activities and meeting agreed upon milestones, funding is available in the FY 2005 budget for this work.

Item

Immunization – The Committee encourages CDC to increase section 317 grant supports for infrastructure development and purchase of vaccines for the State of Alaska's universal immunization program. It has been brought to the Committee's attention that infrastructure costs of delivering vaccines to children in Alaska are substantially higher than in other areas of the country, because of the many small, remote communities which must be served primarily by air. The Committee encourages the agency to give careful consideration to Alaska's request for sufficient funding for the purchase of vaccines needed for 90 percent of Alaskan children and to provide infrastructure support needed to deliver these vaccines at the community level, including development of a statewide immunization registry to ensure that all children in Alaska are immunized. The Committee notes that failure to immunize children in remote areas of Alaska results in deaths each year from exposure to open sewage lagoons and contaminated water. **(Page 69)**

Action taken or to be taken

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

Item

Cooley's Anemia -- The Committee is pleased with the progress that CDC has made with regard to the establishment of a blood safety surveillance program for Cooley's anemia patients, who are the largest consumers of red blood cells. The program involves six treatment centers that handle the medical aspects, and the Cooley's Anemia Foundation that provides education and awareness, patient recruitment, and other services, while CDC is creating an archive of tested and analyzed blood samples. As the program moves forward and one time costs are met, the Committee urges the CDC to direct an increasing amount of the funds available to active patient recruitment, education and awareness, and related services. **(Page 73)**

Action taken or to be taken

CDC will maintain support to the network of six Thalassemia Treatment Centers (TTCs) in the United States that promote the management, treatment, and prevention of complications experienced by persons with thalassemia. These centers initiated patient enrollment in CDC's Thalassemia National Data Collection Project, the purpose of which is to establish a blood safety monitoring system and to assist with the analysis of a uniform set of clinical data routinely collected on enrolled patients. TTCs have enrolled 30% of the active patient population seen in their centers during the fourth quarter of 2004. The TTCs and DHBD collaborated with the Cooley's Anemia Foundation (CAF) to enhance thalassemia outreach and education. CAF provided information on state of the art medical treatment to patients and health care providers and assisted TTCs with local outreach efforts. Current programs will be modestly expanded to identify more patients with thalassemia.

Item

Delta Health Initiative -- The Mississippi Delta Region experiences some of the nation's highest rates of chronic diseases, such as diabetes, hypertension, obesity, heart disease and stroke. The Committee recognizes the efforts of the Delta Health Alliance in health education, coordination of health services and health-related research in the Mississippi Delta. The Committee believes that such collaborative, community-based programs offer the best hope for breaking the cycle of poor health in underprivileged areas such as the Mississippi Delta. The Committee recommends that the CDC collaborate with the Delta Health Alliance in addressing the chronic health issues of the Mississippi Delta. **(Page 73)**

Action taken or to be taken

The CDC-Delta Prevention Collaborative is a strategy to achieve better health and productivity for the people of the Delta Region in Mississippi. More than half a million citizens -- 1/5 of Mississippi's population -- live and work in this northwest region of the state. Half of the area is rural, and most of the 18 counties have fewer than 40,000 residents. Health and economic indicators show the region to have lower life expectancies from birth, poorer health and less health insurance coverage, and higher unemployment and lower incomes in comparison to other state regions or neighboring states. These measures add up to a significant public health challenge.

CDC's is currently collaborating with the Delta Health Alliance and proposing activities that would support the interest of this language. Partners from the state of Mississippi are coming together to find ways to better address the health and productivity of the Mississippi Delta region. Delta residents -- together with partners from within the state and CDC -- can dramatically reduce the burden of chronic disease and injury, work to eliminate health disparities, and assure the conditions for a healthier, more prosperous future in the region.

Examples of possible future activities that have been discussed include: the development and application of models for rural chronic disease prevention, health promotion, and injury prevention to improve health and quality of life in the Mississippi Delta Region -- specifically addressing heart disease, stroke, obesity, diabetes (including disease management), tobacco activity, asthma, and injury prevention; development and implementation of an integrated chronic disease collaborative model with a focus on public health research and community, school, and worksite-based interventions in order to ultimately reduce health disparities and enhance state and local infrastructure; facilitate and lend support to the emerging collaboration among Delta State University's Research Center, Delta Valley State University, Mississippi State University, and University of Mississippi Medical Center, Department of Education, the Delta Council, and other state/local organizations now allied as the Delta Health Initiative.

Item

Diabetes -- The Division of Diabetes Translation (DDT) is charged with addressing diabetes public health issues across the country. This is done primarily through funding State Diabetes Prevention and Control Programs. The Committee encourages CDC to fund as many states as possible at the basic implementation level. (page 73)

Action taken or to be taken

CDC's state-based Diabetes Prevention and Control Programs (DPCPs) funded at the basic implementation level implement various state-wide activities that improve access to quality diabetes care, increase public and health care provider knowledge about practices to prevent diabetes and its complications, and involve communities and local organizations in diabetes prevention and control activities throughout the state. CDC currently funds 26 DPCPs at the basic implementation level. With a portion of the increased funding in FY 2005, CDC will fund an additional one to three states at the basic implementation level. These states will build on the strengths developed as a capacity building DPCP and expand activities to reach and impact more people with diabetes throughout the state. The number of states to be promoted from capacity building to basic implementation will be based upon past performance and the strength of the state's revised work plan, and upon final estimated cost of the new state-based primary prevention pilots, which CDC will launch with a portion of the increase in FY 2005 funds.

Item

Diabetes – The Committee has provided \$5,000,000 over the fiscal year 2004 funding level for diabetes-related activities at the CDC. The Committee encourages CDC to work with State Diabetes Control Programs to establish pilot projects to test strategies that will become effective public health interventions to prevent or significantly delay the onset of diabetes in high-risk individuals and develop systems to identify and monitor the number of people who are at highest risk for developing diabetes. **(Page 73)**

Action taken or to be taken

CDC will use a portion of the FY 2005 increase in funds of \$4,043,000 to build on preliminary state-based primary prevention efforts. In FY03, CDC funded 6 DPCPs to develop diabetes prevention models that would integrate chronic disease prevention approaches to address type 2 diabetes prevention in those at highest risk. The evaluation of this project is underway and the findings will be available in 2005. CDC is also working with HRSA's Bureau of Primary Health Care community health centers to develop effective strategies for identifying those with pre-diabetes, and for preventing those individuals from developing type 2 diabetes. Preliminary results from the CDC/HRSA collaboration have been very encouraging that it is possible to effectively identify pre-diabetes in a clinical setting and provide lifestyle interventions that can help prevent the onset type 2 of diabetes. CDC anticipates that this initial work has provided a solid foundation for the development of robust and effective state-based primary prevention pilots which will involve state DPCPs and other partners.

Item

Geraldine Ferraro Cancer Education Program – The Committee expects CDC to increase efforts to address hematologic cancer survivorship issues and improve quality of national hematologic data. The Committee strongly encourages CDC to support activities related to the development of interactive web based education for health care providers on the signs, symptoms and current treatment of blood cancer by comprehensive cancer centers. **(Page 74)**

Action taken or to be taken

CDC currently funds nine national organizations to provide blood cancer information and education to patients, their family members, friends, caregivers, and health care providers. This effort will assist national health organizations in the development and implementation of strategies to promote and disseminate information on hematologic cancers; increase awareness of support services for those affected by these types of cancer, and expands provider education efforts in this area. The educational materials will be appropriate to the culture, language, and reading level of medically underserved populations and lower literacy English-speaking patients to increase awareness of these materials and available services among healthcare providers and community organizations.

This vital health information will include a CD-ROM, an interactive website, and downloadable educational materials. Information will be disseminated to health care providers, social workers, patient educators, public hospitals, cancer centers and community based organizations. Some of the materials being developed will go directly to nationwide patient and provider education and outreach programs to increase awareness of treatment options and clinical trials among physicians, to improve the reach and effectiveness of patient education strategies, and to increase the awareness of hematologic cancer resources among patients and providers.

In addition, CDC is working to improve the quality of blood cancer data. Cancer registry data are the foundation for public health efforts and the data collected by state cancer registries enable public health professionals to better understand and address the cancer burden. CDC hopes to improve cancer registry data through better, more specific coding for specific types of blood cancers. Ultimately, a better analysis of proper coding and collection of data would vastly expand available information about different blood cancers and provide a better overview of state-by-state burden.

CDC is also supporting hematologic blood cancer survivorship issues through the National Comprehensive Cancer Control program. This program is expanding cancer survivorship activities through supplemental funding to state health departments.

In addition, CDC will work with NCI's Office of Cancer Survivorship to support research on blood cancer survivors that are of mutual interest to both agencies.

Item

Heart Disease and Stroke – Concerned that the CDC lacks a Division to address heart disease and stroke, the Committee encourages the agency to consolidate and elevate its efforts on these diseases by creating a Heart Disease and Stroke Division. (Page 74)

Action taken or to be taken

CDC appreciates the Committee's interest in CDC's heart disease and stroke prevention program. In FY 2005, CDC will expand its efforts to prevent heart disease and stroke, the first and third leading causes of death in the U.S. Currently, CDC is evaluating the resources and other changes needed to establish a heart disease and stroke division within CDC.

Item

Oral Health – The Committee recognizes that to effectively reduce disparities in oral disease will require improvements at the State and local levels. The Committee has provided additional funding to States to strengthen their capacities to assess the prevalence of oral diseases, to target interventions, like additional water fluoridation and school-linked sealant programs, and resources to the underserved, and to evaluate changes in policies, programs and disease burden. The Committee also expects the CDC to advance efforts to reduce the disparities and the health burden from oral cancers and oral diseases that are closely linked to chronic diseases like diabetes and heart disease. (Page 76)

Action taken or to be taken

CDC is working with 12 states and 1 territory to build capacity for effective oral health prevention programs and to reduce disparities among disadvantaged populations. This effort includes working with states to develop school-based or school-linked programs to reach children at high risk of oral disease with proven and effective education and prevention services, such as dental sealants. CDC also works with states to expand the fluoridation of community water systems and operates a fluoridation training and quality assurance program. In addition, CDC will expand its efforts to assess the extent of oral diseases, target prevention programs and resources to those at greatest risk, fund prevention research, and evaluate changes in policies and programs to reduce disparities. CDC will continue to develop methods to identify and reach adults at greatest risk of oral diseases associated with other chronic diseases (e.g., diabetes and heart disease) and their risk factors.

Item

Nutrition, Physical Activity and Obesity – The Committee encourages CDC to develop model programs that assist African American and Hispanic grandparents in encouraging their grandchildren to eat more healthfully and be more physically active. (Page 77)

Action taken or to be taken

CDC acknowledges the importance of grandparents in the care and upbringing of their grandchildren and their responsibility in helping them acquire lifelong skills such as eating healthfully and being physically active. CDC is currently conducting research in this area among African American and Caucasian groups to develop culturally-sensitive and effective teaching tools to improve parenting skills with regard to child feeding practices. The objectives of the formative research study were to: (1) determine the perceptions, opinions, beliefs, and attitudes of parents regarding healthy eating practices, (2) determine who is responsible for decisions concerning food choices in the home, (3) assess what parents are willing to do to prevent childhood obesity (change their own behavior), (4) assess the incentives that will motivate parents to begin serving more healthy foods to their children, and (5) evaluate the Picky Eater Tip Sheet. The tools, a videotape and tip-sheet, was developed to assist medical practitioners and public health clinics reach parents with messages on parenting, child feeding, and healthy eating practices. These research and programmatic activities will inform future efforts to develop resources for grandparents.

Item

Prader-Willi Syndrome – Prader-Willi Syndrome is the most common known genetic cause of life-threatening obesity in children. The Committee encourages the CDC to initiate a study of the incidence rate of Prader-Willi

Syndrome and to provide a system for tracking the complications from the syndrome including causes of premature death. Additionally, early diagnosis and treatment is crucial to the proper treatment of Prader-Willi Syndrome and can significantly reduce the long term care costs. The Committee encourages the CDC to develop and disseminate educational materials to clinicians, educators, and parents in collaboration with voluntary organizations. **(Page 77)**

Action taken or to be taken

CDC shares the committee's concerns about genetic conditions, including Prader-Willi syndrome. CDC's Atlanta-based model birth defects tracking program does not currently have the capacity to accurately determine the birth prevalence of this condition. CDC is assessing what information exists on Prader-Willi syndrome within CDC's network of state-based birth defects programs, and whether the existing infrastructure provides a reasonable approach to collecting additional information. CDC will explore options to work with partners to develop and disseminate educational materials on Prader-Willi Syndrome.

Item

Prostatitis – The Committee understands that chronic prostatitis affects 10 percent of the male population and may act as a reservoir for bacterial resistance and contribute to the spread of chronic disease in men and women by various pathogens. The Committee urges the CDC to continue and expand its investigation of the etiology of prostatitis. **(Page 78)**

Action taken or to be taken

Over the past two years, CDC has modified new laboratory technology to explore the possible role of infectious biofilms in chronic prostatitis. CDC will complete the pilot study this year, using the resulting information to direct future studies that improve understanding the relationships between infection and chronic prostatitis and their potential impact on other chronic prostate disease. Such knowledge can enhance educational, research and prevention efforts in this area.

Item

Sleep Disorders –The Committee is concerned about the prevalence of sleep disorders and recognizes the need for enhanced public and professional awareness on sleep and sleep disorders. The Committee urges CDC to work with other agencies and voluntary health organizations to support the development of a sleep education and public awareness initiative. Several agencies have had success with this collaborative model. **(Page 78)**

Action taken or to be taken

According to research, one quarter of all Americans suffer from frequent sleeplessness, defined as insufficient sleep or rest for at least 14 of the last 30 days. Frequent sleeplessness is inversely related to age, being reported by 34.1% of younger adults. Notably, individuals reporting frequent sleeplessness are also significantly more likely to report fair or poor general health, frequent mental distress, frequent depressive and anxiety symptoms, and activity limitations. Health risk behaviors – such as smoking, physical inactivity, and obesity – are also significantly more prevalent among respondents reporting frequent sleeplessness. Thus, the prevalence of disturbed sleep and the gravity of its correlates suggest that sleep is an important area for public health assessment and intervention. CDC currently participates on the Sleep Disorders Research Advisory Board, housed within the National Heart Lung and Blood Institute at the National Institutes of Health.

Item

Steps to a HealthierUS – The Committee applauds the Department's continued commitment to tackling the problems of obesity, diabetes, and asthma. The Committee agrees that these are three of the most critical chronic conditions afflicting Americans. The Committee is concerned that existing programs that address these problems have not yet been implemented in all of the States. The Committee has increased funding for this initiative and also increased existing programs within CDC that are aimed at obesity, diabetes, and asthma. The Committee strongly urges CDC to coordinate the efforts of these programs such that the best possible outcome is achieved using these funds. **(Page 78)**

Action taken or to be taken

The Steps to a HealthierUS cooperative agreement program relies on the support, infrastructure, and resources established and maintained by the existing categorically funded CDC chronic disease programs. The Steps program has been established as an extension of CDC's state-based programs to enhance, expand, and create a crosscutting and integrated approach to address the collective goals of chronic disease prevention.

The combination of categorical and crosscutting funding provides both expertise on the complex issues of disease and risk factors and allows for comprehensive programming based on effective practice that addresses the needs of the community.

The Steps communities' experience indicates that it is critical that both state and community efforts are made to most effectively provide chronic disease prevention programming. State involvement provides the infrastructure for state planning and coordination, while direct and substantial community activities allows the plans to be operationalized to address identified community needs.

The Steps program will continue to coordinate crosscutting activities at the national, state and community level through shared and integrated staffing, technical assistance and evaluation activities.

Item

Sudden Infant Death Syndrome – The Committee notes the work of CDC, the National Institute of Child Health and Human Development and the Health Resources and Services Administration in developing model guidelines for death scene protocol for Sudden Infant Death Syndrome. The Committee continues to encourage CDC to implement projects to demonstrate the effectiveness of the death scene protocol in a variety of locales (urban, suburban, and rural) throughout the Nation. The Committee looks forward to reports of progress on this initiative as was requested in the fiscal year 2004 Committee report. **(Page 79)**

Action taken or to be taken

CDC convened a team of infant health experts to review and revise the 1996 infant death scene protocol model guidelines. The 1996 death scene model protocol guidelines have been demonstrated to be cumbersome and not generally usable. Less than one-fourth of respondents (21%) reported using the form. The most cited reasons for not using the form were the length of the form or a preference or mandate to use existing local or state forms. In 2004, CDC and its partners revised the 1996 Guidelines for Death Scene Investigation of Sudden Unexplained Infant Death and the Sudden, Unexplained Infant Deaths Investigation Report Form (SUIDIRF).

CDC field tested and evaluated the guidelines and form between July and November 2004. In December 2004, CDC established a national SUIDIRF Training and Dissemination Work Group which includes consumers and public- and private-sector partners. This group will review the final version of the revised SUIDIRF, review drafts of the training curriculum and materials, and assist CDC in refining and finalizing the dissemination plans. Final revisions will be complete by summer 2005. The revised guidelines will include minimum standard information to ensure national consistency, but not a mandated format.

Item

Worksite Health Promotion – The Committee commends CDC for its efforts to evaluate worksite health promotion programs including the impact that such programs have on reducing health risks, health insurance costs, and employee absenteeism. The Committee encourages CDC to develop an employer wellness model program based on the results of these studies and disseminate that information to businesses. **(Page 79)**

Action taken or to be taken

Worksite health promotion continues to be an area of increasing attention by both researchers and practitioners. Many Americans spend the majority of their waking hours five days a week at work, and the workplace continues to be the venue through which most Americans of working age get their medical insurance. Spiraling costs of medical care, which concerns employees and employers, as well as the number of hours spent at work, make the worksite an obvious setting for health promotion interventions.

CDC is identifying and evaluating the effects and impact of worksite health promotion programs on employees. CDC is currently developing a chapter specific to worksite health promotion for the Guide to Community Preventive Services, by conducting a gap analysis and comprehensive review of existing literature and studies on worksite health promotion. CDC will then revise the Guide to Community Preventive Services chapters on obesity and other relevant topics to include evidence-based worksite health interventions for employers. CDC is also exploring the feasibility and approach for developing a business nationwide surveillance system for worksite health promotion policy and practice. CDC expects to have these tools available in 2007.

Item

Childhood Obesity Prevention in Children with Special Health Care Needs – As authorized under Title XXIV of the Children's Health Act of 2000, the Committee encourages the CDC to fund public health research, surveillance and educational activities related to obesity among children with special health care needs, with a special emphasis on children with Prader-Willi Syndrome. **(Page 80)**

Action taken or to be taken

Obesity has reached epidemic proportions. In the past 20 years, the prevalence of obesity has increased by more than 60% among adults, has doubled among children, and has tripled among adolescents. Sixteen percent of children and adolescents are overweight and more than half of these children have at least one cardiovascular disease risk factor, such as high cholesterol or hypertension. Children with special health care needs face additional challenges to physical activity due to mobility and other limitations. CDC is currently developing an agency-wide obesity action plan to be released in 2005. The unique concerns of children with special health care needs will be addressed within this plan.

Item

Thrombophilia – The Committee understands that at least 1 in 15 Americans has thrombophilia, which increases their risk of developing life threatening thrombosis (blood clots), and 60,000 deaths annually are directly attributable to blood clots. Many more die from blood clot related complications. The Committee is concerned that physicians and the public are poorly informed about the risks of thrombosis and thrombophilia. CDC has funded eight sites to begin gathering information on the dimensions of this disease and related thrombosis. The Committee encourages the CDC to expand the number of sites to address the dimensions of this widespread public health problem. (Page 83)

Action taken or to be taken

CDC implemented a pilot program to expand the scope of the hemophilia treatment network to integrate services for persons with thrombophilia by providing support to eight Hemostasis and Thrombosis Center sites. The sites in collaboration with CDC have developed a data collection study to determine the genetic and environmental factors that cause or trigger activation of abnormal blood clotting. The sites are also exploring models of care for secondary prevention and management of thrombosis. Funding currently supports eight programs.

Item

Asthma – The Committee is pleased with the work that the CDC has done to address the increasing prevalence of asthma. However, the increase in asthma among children remains alarming. The Committee urges CDC to expand its outreach aimed at increasing public awareness of asthma control and prevention strategies, particularly among at-risk populations in underserved communities. To further facilitate this effort, CDC is urged to partner with voluntary health organizations to support program activity consistent with the CDC's efforts to fund community-based interventions that apply effective approaches demonstrated in research projects within the scientific and public health community ... the Committee commends CDC's efforts to collect national and local data on the incidence and prevalence of asthma and to implement asthma prevention programs. The Committee encourages CDC to continue with these activities and expand its prevention programs into areas of high pediatric asthma incidence. (Page 84/85)

Action taken or to be taken

CDC is further expanding its outreach aimed at increasing public awareness of asthma control and prevention strategies, particularly among at-risk populations in underserved communities. This year, through its National Asthma Health Education Enhancement effort, CDC has funded voluntary health organizations such as the American Lung Association, the Allergy and Asthma Network/Mothers of Asthmatics, and the Asthma and Allergy Foundation of America to conduct activities related to asthma education. These activities range from identifying effective educational programs for adults that can be adapted for nationwide use to educating children with asthma and their families and caregivers. In addition, in 2005 CDC will announce a new opportunity for voluntary health organizations to collaborate with CDC to work with the underserved populations that they serve. CDC is also funding six national nongovernmental organizations, 7 urban school districts, and 1 state education agency to implement strategies within a school-based environment to reduce asthma episodes and related school absences, especially among youth who are at highest risk.

CDC has also created a Web site (<http://www.cdc.gov/nceh/airpollution/asthma/interventions/interventions.htm>) for state and local public health organizations and others called "Effective Interventions for Asthma Control" to provide information on "what works" as well as to provide access to materials that can be used to adapt and implement the interventions.

CDC has successfully added asthma prevalence questions to the Behavioral Risk Factor Surveillance Survey, the National Youth Risk Behavior Survey in 2003, and the state and city Youth Risk Behavior Survey in 2005. Asthma prevalence data will now be available to all 50 states, Washington DC, and 3 territories. CDC is also developing the National Asthma Survey (NAS) which is a comprehensive state/city level detailed asthma survey. In addition, CDC funds 35 state/city/territories to develop and implement asthma surveillance programs within their jurisdictions. The results of all of these programs are used to plan, implement, target, and evaluate intervention activities. CDC is also

funding the Kaiser Foundation Research Institute and the Miami-Dade County Health Department to implement population-based asthma incidence surveillance programs.

Item

Environmental Health Workforce – The demand for environmental health services had expanded to include external and internal air quality, drinking water quality, food safety, childhood lead poisoning, asthma control, rodent control, and hazardous chemical control and management. In addition, city and state environmental health personnel are responsible for providing the initial response to acts of chemical and radiological terrorism. In light of this increased demand and our country's reduced capacity, the Committee is concerned about the need to enhance and revitalize environmental health services at the national, state, and local levels. (Page 85)

Action taken or to be taken

CDC operates an environmental health services program, which exists to support state, local, tribal, and national environmental health programs and practitioners to better anticipate, identify, and respond to adverse environmental exposures (biological/chemical/radiological) and the consequences of those exposures to human health. CDC directly and through its numerous partners provides assistance, conducts research and evaluations, trains practitioners and funds environmental health programs that enable local, state, and tribal organizations to address a wide variety of environmental health issues

CDC developed environmental health training products to promote state-of-the-art environmental health practice and provided technical assistance to more than 25 state, local, and tribal environmental health programs responding to disasters and food, water, and vector-borne outbreaks. In addition, CDC maintains an Environmental Public Health Inquiry Tracking System to monitor and respond to environmental public health inquiries related to water, sewage, food, indoor air quality, mold and vectors. To further enhance and revitalize environmental health services, CDC funded 16 state and local health agencies to build capacity by utilizing the 10 essential public health services framework and funded 11 schools of public health to assist state and local health departments in developing state-of-the-art environmental public health programs. CDC also supported 8 states in the development of a network of environmental health specialists that collect, analyze, and disseminate information on the factors that contribute to food borne illness and outbreaks.

Item

Health Tracking Network – With health tracking, public health officials can better target preventive services, health care providers can offer better health care, and the public will be able to develop a clear understanding of what is occurring in their communities and how overall health can be improved. The initial efforts to establish such a Network are now being carried out through a series of state grants to develop pilot initiatives and projects. The Committee understands that a critical component of the nationwide tracking program is assuring that communities are engaged in the process of developing the state-based networks and informed of the results. The Committee urges CDC and the state and local programs to work with the citizens in local communities. (Page 86)

Action taken or to be taken

CDC has taken and will continue to take specific steps in its National Environmental Public Health Tracking (EPHT) Program to ensure that communities are engaged in the process of developing the State-based networks and are informed of the results. CDC and funded state and local programs will also continue to work with citizens in local communities through continued involvement in a variety of activities designed to provide an opportunity to share information about the program and to receive feedback from community members. In addition, CDC has created a listserv so that external partners can receive updated information on the program, its activities, and progress. Through a designated e-mail address, CDC also receives comments, input, and requests related to tracking from outside stakeholders. CDC currently is drafting a more detailed strategic plan for the National EPHT Program and will be sharing the draft with outside stakeholders, including citizens of local communities, to obtain their feedback and input.

In addition to the steps that CDC is directly taking to ensure community engagement, CDC's grantees are also taking steps to involve constituents at the local and community level in planning, developing, and implementing EPHT. An example of this is that two of CDC's EPHT grantees have implemented mini-grant programs. In one state these mini-grants are designed to help build environmental public health capacity in selected local health departments and in the other state these grants are used for projects to address local capacity in accessing, understanding, analyzing, and/or utilizing environmental health data for public health functions. In addition to mini-grants, grantees have implemented activities to ensure that their programs are continually working with citizens and local communities.

Item

Perchlorate Contamination – The Committee is concerned about contamination due to perchlorate, which is primarily used as an oxidizer for rocket fuel and munitions. Perchlorate contamination has been discovered in 34 States and is known to have adverse health effects on pregnant women, newborns, and young children. The Committee strongly urges the CDC to conduct surveys on the level of perchlorate in humans, to provide information for assessments on a national level, and to address regional concerns in areas most affected. **(Page 86)**

Action taken or to be taken

CDC's Environmental Health Laboratory has developed an analytical biomonitoring method for measuring levels of perchlorate in people's urine using ion chromatography and electrospray tandem mass spectrometry. Using this state-of-the-art approach, laboratory scientists will measure levels of perchlorate from participants in CDC's National Health and Nutrition Examination Survey (NHANES). NHANES is a series of surveys designed to collect data on the health and nutritional status of the U.S. population. CDC's Environmental Health Laboratory publishes data on the exposure of the U.S. population to environmental chemicals in its biennial *National Report on Human Exposure to Environmental Chemicals*. Two Reports have already been issued; the *Third Report*, which is slated for release in early spring of 2005, will contain human exposure data on 149 environmental chemicals. The *Fourth Report*, which will contain data on levels of perchlorate in the U.S. population, will be published in 2007. With these data, we will have baseline levels in the U.S. population and will be able to compare them with levels found in specific populations that may have been exposed to perchlorate.

Item

Primary Immunodeficiency Diseases – In each of the last 3 years, Congress has made available funds for CDC to support the national physician education and public awareness campaign developed by the Jeffrey Modell Foundation. The Foundation has leveraged more than \$7 from donors and the media for every Federal dollar appropriated and is a model of public-private cooperation. The campaign has featured physician symposia, publications, public service announcements, and the development of website and educational materials, as well as mailings to physicians, school nurses and others. This very successful physician and public awareness campaign now must expand its reach to underserved communities, including African-American and Hispanic populations, and the Committee has provided sufficient funding to reach that critical goal. In addition, the Committee encourages CDC to expand its programmatic activity on primary immune deficiency diseases to include pilot programs focused on newborn screening and school wellness. The Committee has provided \$1,000,000 over the fiscal year 2004 level for these purposes. **(Page 86)**

Action taken or to be taken

CDC will provide funding to the Jeffrey Modell Foundation for FY2005 for the fourth consecutive year to continue their work in physician and public education related to primary immunodeficiency diseases. As recognized leaders in this area, JMF considers the program to be very successful and effective. The Conference awarded an additional \$500,000 to the Foundation to continue efforts on a physician education and public awareness program for primary immune deficiency disease. CDC will continue to support JMF in these efforts.

Item

Severe Combined Immune Deficiency Disease – It has come to the Committee's attention that NIH has developed the technology to screen newborns for severe combined immune deficiency disease [SCID] or "the bubble boy disease." The Committee commends the Newborn Screening Branch at the National Center for Environmental Health at CDC for their commitment to developing a newborn screening program for SCID. The Committee encourages the CDC to consider support for the development of a newborn screening program for SCID. **(Page 86/87)**

Action taken or to be taken

CDC's Environmental Health Laboratory would welcome the opportunity to develop a newborn screening program for SCID. CDC's National Center on Birth Defects and Developmental Disabilities supports the idea that the newborn screening test for SCID developed at NHGRI appears promising and that pilot testing using a population-based sample is important to do in order to validate the test. The National Center on Birth Defects and Developmental Disabilities looks forward to providing technical consultation to the National Center on Environmental Health and NHGRI as they move forward with this proposed activity.

Item

Fire and Fall Injury Prevention – CDC funds five States to implement and evaluate “Remembering When: A Fire and Fall Prevention Program,” directed at older adults. The Committee encourages CDC to continue the implementation of this project. **(Page 87)**

Action taken or to be taken

From October 2000 – September 2003, CDC funded state health departments in Arkansas, Maryland, Minnesota, North Carolina, and Virginia to implement and evaluate “Remembering When: A Fire and Fall Prevention Program,” which teaches older adults how to prevent fires and falls. CDC is currently not funding states for implementation of “Remembering When...,” however, CDC funded Georgia State University to evaluate the effectiveness of “Remembering When.” The evaluation includes an examination of knowledge and skills needed to reduce falls and fires. Having received the evaluation results in December, 2004, CDC will use these results to make informed decisions about future program activities and for widespread dissemination of the program.

Item

Rape Prevention and Education – The CDC provides one of the only sources of funding for rape prevention and education. Most other funding sources are focused on services to survivors and the criminal justice system. The Committee urges CDC to ensure that States receiving funds from the grants for assistance to victims of sexual assault, as provided in the Violence Against Women Act, support State sexual assault coalitions, community-based rape crisis centers, and other non-profit entities whose work is focused on ending sexual violence, operating hotlines for victims of sexual violence and their families, and those which provide crisis intervention, advocacy and support services to victims. The Committee urges the CDC to ensure that States work collaboratively with State sexual assault coalitions in planning and funding activities. The Committee has provided \$2,000,000 over the fiscal year 2004 level for these activities. The Committee recommends that a portion of these additional funds be used to fund awareness activities and materials in conjunction with Sexual Assault Awareness Month. **(Page 87/88)**

Action taken or to be taken

CDC administers and provides technical assistance for the Rape Prevention and Education (RPE) Program to health departments and sexual assault coalitions. This program supports educational seminars, hotline operations, and training programs for professionals, informational materials and other efforts designed to increase awareness of sexual violence. Through this program, states and territories have implemented prevention and education programs and developed a stronger infrastructure to address sexual violence. CDC fosters collaboration with State sexual assault coalitions by ensuring their participation in CDC sponsored technical assistance, training and grantee site visits. Furthermore, CDC encourages state RPE grantees to collaborate with their State sexual assault coalitions in their rape prevention and education program endeavors. Ongoing communication with the State sexual assault coalitions is supported through the National Sexual Violence Resource Center.

Additionally, CDC funds the National Sexual Violence Resource Center (NSVRC), a project of the Pennsylvania Coalition Against Rape, to assist in providing national leadership for Sexual Assault Awareness Month (SAAM). In order to aid local, state and national sexual assault programs and communities in planning SAAM events, NSVRC creates SAAM Campaign Packets which include posters and other products that these programs can customize with their individual information. As well as providing materials and technical assistance to others in planning and implementing SAAM campaigns, NSVRC works with various media outlets to publicize SAAM. NSVRC is also a comprehensive center which provides resources to be used against sexual assault. The Conference Committee awarded an additional \$1,000,000 over FY 2004 to be used to expand rape prevention and education activities, including expanding the NSVRC and to support activities surrounding Sexual Assault Awareness Month.

Item

Suicide Prevention – The Committee encourages CDC to conduct suicide prevention research and support demonstration projects to identify promising and effective suicide prevention strategies. Research will enhance the knowledge base about risk and protective factors and the consequences of suicidal behavior in order to develop more effective prevention strategies. **(Page 88)**

Action taken or to be taken

CDC funded two states, Maine and Virginia, to implement and evaluate interventions for preventing youth suicide in FY 2004. This funding provides the necessary resources to progress from data gathering and analysis to identifying best practices for suicide prevention and promoting program evaluation.

In FY 2004, CDC supported two new suicide prevention research projects. The first is designed to examine service utilization by vulnerable youth following a suicide screening program. This project will expand efforts to optimize

youth suicide screening programs by establishing a better understanding of the course of both suicidal adolescents' improvement and use of services after a screening program. Information obtained from this study is critically needed to establish effective screening programs to prevent suicidal behavior in youth. The second project tests the efficacy of a brief family therapy for adolescents presenting with serious risk for suicide in a primary care setting. These patients will immediately be identified and treated in that setting.

Item

Traumatic Brain Injury (TBI) – The Committee understands that a National Information Center for Traumatic Brain Injury is expanding as a pilot program providing persons with brain injury, their families, and those who serve them with toll-free information on State-specific resources and linkage to service. The Committee encourages the CDC to be supportive of this National Information Center. The Committee also encourages the CDC to fulfill its duties under the TBI Act as part of the Children's Health Act, such as monitoring the outcomes and services of people who sustain injuries, including TBI, during mass casualty events such as a terrorist attack; strengthen support for State and local efforts to collect data on TBI; increasing education and awareness efforts; conduct public health research related to TBI and collecting annual incidence and outcome data on "mild" TBI. **(Page 88)**

Action taken or to be taken

CDC continues to fulfill its duties under the TBI Act by collecting data on traumatic brain injuries, funding public health research related to TBI, educating the public and professionals about TBI and helping link people with TBI to needed services.

CDC has provided funding to the Brain Injury Association of America in support of a pilot study to evaluate the possible development of a national brain injury information center. The concept behind the information center is to provide persons with brain injury, their families and agencies that serve them with information on state-specific resources and services available to them. The "one-call" information center will initially be piloted in two states, and may eventually include a national toll-free telephone number with automatic down-links to telephone numbers of state and/or local agencies that can provide information about resources at the local level.

CDC has funded more than 15 state health departments to determine the number of persons who seek care in the emergency department or other hospital care, sustain TBI-related disabilities or who die due to TBIs. States use these data to develop programs to prevent TBIs, educate the public about TBIs and to identify the need for services for persons with TBIs.

CDC has also produced a new report entitled "Traumatic Brain Injury in the United States: Emergency Department Visits, Hospitalizations and Deaths." This report provides detailed information about traumatic brain injury (TBI)-related deaths, hospitalizations, and emergency department (ED) visits in the United States. The data can be used to address a wide range of important questions, such as how many TBIs occur each year in the United States, who is affected and how these TBIs occur.

Item

Violence Against Women – The Committee urges the CDC to increase research on the psychological consequences of violence against women and expand research on special populations and their risk for violence including adolescents, older women, ethnic minorities, women with disabilities, and other affected populations. **(Page 88)**

Action taken or to be taken

CDC conducts both intramural and extramural research to address the psychological consequences of violence against women. For example, CDC funded Emory University to conduct a research study at Grady Hospital that examined the links between suicide attempts and intimate partner violence. Another study at the University of Arizona is conducting an intervention study that employs a psychological intervention with perpetrators to lessen the psychological trauma affecting victims. CDC is also investigating the psychological influences that perpetuate violence against women. More specifically, CDC is conducting a study to determine the extent to which batterers and non-batterers can be distinguished on the basis of issues surrounding power and control in response to violence.

Regarding research on special populations, CDC is completing a 5-year cooperative agreement program that funded 4 research demonstration projects for the early intervention and prevention of intimate partner violence and sexual violence among racial and ethnic minority populations. In FY 2005, CDC has proposed to fund research examining dating violence among adolescents.

Item

Occupational Safety and Health - Congress established NIOSH with the expressed intent "to provide occupational safety and health research with the visibility and status it merits" and "to elevate the status of occupational safety and

health research” (Legislative History of the Occupational Safety and Health Act of 1970, S. 2193, Public Law 91-596). The Committee strongly supports these principles. The Committee expects CDC to ensure that the ongoing CDC reorganization does not impede nor diminish NIOSH’s ability to meet its statutory responsibilities to protect the safety and health of America’s workers. The Committee believes that NIOSH must have the stature necessary to work effectively with OSHA, the Department of Labor, and the Department of Health and Human Services in the manner described by statute. Therefore, the Committee directs the CDC to maintain the status quo with respect to the direct reporting relationship of the NIOSH director to the CDC director. The Committee further directs the CDC to: (1) make no changes to NIOSH’s current operating procedures and organizational structure and (2) ensure that no funds or personnel will be transferred from NIOSH to other components of CDC by means other than traditional reprogramming of funds. **(Page 89)**

Action taken or to be taken

CDC will make no changes to NIOSH’s current operating procedures or organizational structure and will ensure that no funds or personnel will be transferred from NIOSH. The NIOSH Director will continue to report directly to the Director of CDC and the NIOSH Headquarters Office will remain in Washington, D.C. In addition, the NIOSH Director will continue to have direct access to the Department of Labor, the Occupational Safety and Health Administration, and the Mine Safety and Health Administration as authorized by Congress. CDC is committed to supporting NIOSH’s success and its impact on preventing work-related injuries, illnesses, and deaths.

Item

Radiation Exposure – The Committee strongly encourages NIOSH to expedite decisions on petitions filed under the Procedure for Designating Classes of Employees as Members of the Special Exposure Cohorts (42 CFR Part 83). It was Congress’ intent in passing the Energy Employees Compensation Act of 2000 to provide for timely, uniform and adequate compensation for employees made ill from exposure to radiation, beryllium and silica, while employed at Department of Energy nuclear facilities or while employed at beryllium vendors and atomic weapons employer facilities. The Committee encourages the Department to recognize that in situations where records documenting internal or external radiation doses received by workers at the specific facility are of poor quality or do not exist that workers should promptly be placed in a special exposure cohort. **(Page 90/91)**

Action taken or to be taken

HHS published the final rule on Procedures for Designating Classes of Employees as Members of the Special Exposure Cohort under the Energy Employees Occupational Illness Compensation Program Act of 2000 (EEOICPA) on May 28, 2004 (42 C.F.R. pt. 83). NIOSH has received 14 petitions since the final rule was published, and is working diligently to complete the research necessary to provide evaluation reports to the Advisory Board on Radiation and Worker Health (“the Board”) for all petitions that have qualified for evaluation. Five petitions, representing 2 facilities covered under EEOICPA, have been qualified, and NIOSH plans to present its research findings concerning those petitions at the next meeting of the Board in February 2005. Three petitions did not qualify for evaluation, proposed findings have been issued for two petitions, one petition was withdrawn by the petitioner, and three petitions are currently in the qualification process. EEOICPA requires the Board to develop and transmit to the Secretary, HHS, and a report containing its recommendations for the Secretary’s consideration in determining whether or not to add a class of employees to the Special Exposure Cohort.

When NIOSH finds that it is not possible to complete a radiation dose reconstruction, HHS will consider this finding sufficient, and without further consideration, determine that it is not feasible to estimate the levels of radiation doses of individual members of the class with sufficient accuracy. NIOSH has not yet reached this finding with respect to any particular dose reconstruction currently underway, but anticipates that some such cases may be identified within the next year.

Item

Research to Practice Initiative – The Committee is supportive of NIOSH’s Research to Practice Initiative to develop and expand efforts to put research findings into practice. The Committee encourages NIOSH to use this initiative to translate useful research findings into best practices, products, and technologies and to disseminate this information to employers and employees to improve the health and safety of workers. **(Page 91)**

Action taken or to be taken

In 2004, NIOSH established an Office of Research and Technology Transfer to ensure that all research funded by NIOSH (both intramural and extramural) is focused on the application of the research findings and inventions toward the prevention of work related illness or injury. This is accomplished by facilitating partnerships throughout the entire research process so that findings are most amenable to implementation; bringing inventions to market; transferring knowledge and products to employers, workers, and policy makers; and evaluating programs for their impact. NIOSH

has determined that for FY 2005 and 2006, all research projects to be funded under the National Occupational Research Agenda (NORA) must be consistent with the research-to-practice principles.

Item

Global HIV/AIDS – The Committee understands that little attention has been given to the increased risk of HIV infection for individuals with disabilities in some parts of the world, including sub-Saharan Africa. Information, testing, and treatment are often inaccessible and denied to individuals with disabilities. The Committee encourages the CDC to investigate this issue and report on the problem and efforts to address it. The Committee also encourages the CDC to provide technical assistance to grantees on how to develop inclusive and accessible public awareness campaigns, educational materials, testing, treatment, palliative and preventive care to ensure that people with disabilities have equal access to services and supports for HIV/AIDS. **(Page 91)**

Action taken or to be taken

CDC has supported efforts to develop specialized services to meet the needs of disabled individuals. For example, to meet the needs of hearing disabled people, CDC recently supported voluntary HIV counseling and testing (VCT) services for the deaf community in Kenya where nearly 900,000 deaf citizens were cut off from this vital information because radio is the prime mode of communication used for AIDS education and services. CDC supported collaboration between the Kenya National Association of the Deaf and Liverpool Voluntary Counseling and Testing (LVCT), and the first Kenyan VCT center for the deaf opened in February 2004. CDC routinely gathers information on these types of programmatic activities so other countries can replicate them, and also routinely supports efforts to implement programs to provide HIV services to individuals with disabilities.

Item

Public Health Research and Prevention Research – The Committee recognizes the need to enhance the recognition and understanding of mind/body medicine's role in the practice of medicine. To foster and expand the uses of mind/body interactions in healthcare and other appropriate settings, the Committee encourages the Public Health Research Program to provide support to research, test, and disseminate the practices related to mind/body techniques. To receive appropriate technical assistance, CDC is strongly encouraged to consult experts in the mind/body field. **(Page 93)**

Action taken or to be taken

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

Item

Diabetes (located in the Office of the Secretary section of report language) – The Committee is aware and very supportive of the Secretary's recently announced Diabetes Detection Initiative, but is concerned about meeting the treatment needs of all the newly diagnosed patients with diabetes. The Committee is aware of the valuable services that certified diabetes educators provide to newly diagnosed patients – teaching them the necessary skills they need to self-manage the disease throughout their life including nutrition, exercise, blood sugar monitoring and medication management. The Committee urges the Secretary to dedicate appropriate resources to conduct demonstrations to

measure the effectiveness of diabetes self-management training in preventing diabetes and the complications it causes. **(Page 221)**

Action taken or to be taken

CDC has conducted an intensive review of diabetes self management interventions and the findings have been published in the Guide to Community Preventive Services. Based on this evidence-based review, CDC found that diabetes self-management resulted in improve glycemic control following the interventions, but the improvements faded over time. CDC encourages AADE to partner with an academic institution to develop a research proposal to further study the effectiveness of diabetes education for self-management of persons with diabetes. CDC would support AADE's efforts to identify federal and non-federal funding streams to support the proposal.

Item

National Children's Study (located in the Office of the Secretary section) – The Committee strongly supports full and timely implementation of the National Children's Study, which aims to quantify the impacts of a broad range of environmental influences on child health and development. The Committee urges the Department to coordinate the involvement of the CDC and the NICHD, and to work closely with the EPA and other interested institutes, agencies and non-Federal partners conducting research on children's environmental health and development so that this study is ready for the field by no later than 2006. **(Page 222)**

Action taken or to be taken

As the largest long-term study of children's health and development ever proposed in the United States, the study holds great promise to help identify the root causes of many of today's childhood and adult diseases and disorders. CDC continues to provide funding and planning support for the National Children's Study, and looks forward to the findings of pilot tests to assist with its possible implementation.

Item

Health Alert Network (HAN) (located in the Office of the Secretary section)– The Committee intended that one function of HAN was to assure that essential, time-sensitive public health information become available to both State and local public health agencies in a timely manner. The Committee is concerned about reports from localities, including large cities, participating in HAN that they are not receiving all CDC-generated messages promptly because such messages are going only to their State agencies. Recognizing that both timeliness and redundancy in communications are important in addressing urgent public health concerns, the Committee strongly urges CDC to ensure that all local public health agencies receive CDC information on the same timely basis as do States. **(Page 226)**

Action taken or to be taken

As part of CDC's PHIN Preparedness Partner Communications and Alerting functional area, the requirements for the delivery of messages have been identified. These requirements assert that the purpose of systems supporting communications and alerting is to inform a designated recipient list about public health events or emergencies using various methods of communication. These requirements also define the parameters for ensuring that messages are delivered to appropriate recipients, based on defined roles, jurisdiction, and urgency of a message. Messages could be delivered using either direct alerting or cascade alerting. In addition, alerting systems must be able to generate a real-time message delivery status report containing the number of recipients targeted to receive a message and the number who have confirmed receipt. A vast majority of the State-based HAN programs have over 90% of their population covered under the umbrella of HAN. The HAN Messaging System currently directly and indirectly transmits Health Alerts, Advisories, and Updates to over one million recipients.

These requirements have been vetted with state and local public health partners this fall and will continue to be refined based on input from other partners. More detail on these requirements can be found at www.cdc.gov/phih/pca.pdf.

Item

Emerging infectious diseases (located in the Office of the Secretary section) – The Committee remains concerned about the emergence of new infectious diseases and the increasing zoonotic disease transmission between animals and humans. As noted in last year's report, some thirty previously unheard of infectious diseases have been discovered in the last 30 years. Increases in human and animal air travel and global commerce provide more opportunities for infectious diseases like SARS, monkey pox and avian flu to spread. The Committee notes that wild animal veterinarians, often located at zoos in populated urban areas, are sometimes the first to see these diseases and can contribute significantly to the detection and understanding of these diseases. The Committee commends the CDC's efforts to merge surveillance systems of State diagnostic labs, veterinary labs, wildlife health

agencies and zoos, and urge the CDC to consider the usefulness of including institutions with live animal collections in the new biosurveillance initiative. **(Page 226/227)**

Action taken or to be taken

To improve surveillance for emerging infections, the Institute of Medicine has recommended enhanced reporting by medical and veterinary partners and development of innovative surveillance strategies that make use of non-traditional data sources, expanded partnerships, and advances in diagnostics, microbial genetics, and satellite imaging. One such mechanism is sentinel surveillance in vectors, wildlife, companion animals, and zoological parks, which could serve as early warning systems for threats to human health. CDC currently sponsors two projects in companion animal and zoo animal sentinel surveillance. The first program is a grant to Purdue University to do surveillance for clinical illness in the companion animal population that might be suggestive of major threats to human health using the electronic veterinary databases from the Banfield Clinics a nationwide group of small animal clinics. The second program is a cooperative agreement with Cornell University to do surveillance for West Nile virus among zoo animals in American Zoological Association member institutions. CDC and Cornell are exploring the potential of this system for surveillance of other zoonotic pathogens.

In 2002 a CDC-FDA-USDA Working Group was tasked to address coordination of human and animal disease surveillance. This group is working to (1) identify needed elements and essential federal state and local partners, which will include representation from agricultural, wildlife, zoo and companion animal sectors; (2) develop a system of communication and triggers for action; (3) divide the workload to maximize efficiency and identify roles and responsibilities; and (4) incorporate animal health surveillance into existing systems. Our vision is to work towards integration of human and animal health surveillance at state, national and global levels, building on current infrastructure already in place, as well as developing new strategies.

EXHIBIT K. SIGNIFICANT ITEMS IN COMMITTEE REPORTS-CONFERENCE

**SIGNIFICANT ITEMS FOR INCLUSION IN
THE FY 2006 CONGRESSIONAL JUSTIFICATION
AND OPENING STATEMENTS
CONFERENCE REPORT NO. 108-792
CENTERS FOR DISEASE CONTROL AND PREVENTION**

Item

Promoting healthy lifestyle with focus on children – The conferees commend CDC on its efforts to promote physical activity among children. In addition to regular physical activity, sound nutrition and healthy eating are important components of good health. The conferees encourage CDC to examine its current activities focused on children and develop options for expanding work related to promoting better nutrition and healthy eating among children. The conferees request that the CDC be prepared to report its findings during the fiscal year 2006 budget hearings. **(Page 1161)**

Action taken or to be taken

CDC is placing a major emphasis on childhood obesity and determining ways to support parents and children in adopting healthier habits around nutrition and physical activity. In the area of healthier eating, CDC is currently conducting intensive focus groups and interviews of food marketing experts, as well as parents and children. The goal is to learn from industry and consumers themselves the most promising ways to market and promote healthy food choices. With this information, CDC will recommend strategies for launching effective campaigns, programs, and interventions at the national, state and local level to educate and motivate parents and children to adopt healthy eating lifestyles. These recommendations and attitudinal findings will be provided in a report to Congress in September 2005.

Item

National Children's Study (located in the Office of the Secretary section) – The Committee strongly supports full and timely implementation of the National Children's Study, which aims to quantify the impacts of a broad range of environmental influences on child health and development. The Committee urges the Department to coordinate the involvement of the CDC and the NICHD, and to work closely with the EPA and other interested institutes, agencies and non-Federal partners conducting research on children's environmental health and development so that this study is ready for the field by no later than 2006. **(Page 222)**

Action taken or to be taken

As the largest long-term study of children's health and development ever proposed in the United States, the National Children's Study holds great promise to help identify the root causes of many of today's childhood and adult diseases and disorders. CDC continues to provide funding and planning support for the National Children's Study, and looks forward to the findings of pilot tests to assist with its possible implementation.

Item

Physician Contact Database – The Committee understands the urgent need to contact, inform and mobilize physicians in public health emergencies and with threats of bioterrorism. The Committee is also aware that CDC is in discussions with the Federation of State Medical Boards to develop an automated data system of physician contact information to be used for these purposes. Within the funding provided, the Committee encourages the Secretary to initiate a pilot project in five states. The Committee requests that the Secretary be prepared to report on plans for the project during the hearings on the FY 2006 budget request. **(Page 150)**

Action taken or to be taken

CDC is developing a pilot physician directory protocol that will enable physician contact information to be incorporated into Health Alert Network (HAN) systems at state and city health departments. Our collaborating partner, the Federation of State Medical Boards, is establishing national standards for state medical boards to obtain, manage, and share physician contact information and to facilitate implementation of data gathering in five pilot states. CDC is ensuring that these standards mesh with the directory and alerting standards being established for public health departments as part of the Public Health Information Network (PHIN) and to test the use of this data in

systems. CDC is working to establish mechanisms to assure the ongoing maintenance and management of physician contact data and its secure, appropriate and timely distribution among public health departments as required during health emergencies.

Item

Diabetes – The Committee is aware and very supportive of the Secretary’s recently announced Diabetes Detection Initiative, but is concerned about meeting the treatment needs of all the newly diagnosed patients with diabetes. The Committee is aware of the valuable services that certified diabetes educators provide to newly diagnosed patients – teaching them the necessary skills they need to self-manage the disease throughout their life including nutrition, exercise, blood sugar monitoring and medication management. The Committee urges the Secretary to dedicate appropriate resources to conduct demonstrations to measure the effectiveness of diabetes self-management training in preventing diabetes and the complications it causes. **(Page 221)**

Action taken or to be taken

CDC has conducted an intensive review of diabetes self management interventions and the findings have been published in the Guide to Community Preventive Services. Based on this evidence-based review, CDC found that diabetes self-management resulted in improve glycemic control following the interventions, but the improvements faded overtime. CDC encourages American Association of Diabetes Educators (AADE) to partner with an academic institution to develop a research proposal to further study the effectiveness of diabetes education for self-management of persons with diabetes. CDC would support AADE’s efforts to identify federal and non-federal funding streams to support the proposal.

EXHIBIT L. AUTHORIZING LEGISLATION*

DOLLARS IN THOUSANDS	FY 2005 AMOUNT AUTHORIZED	FY 2005 APPROPRIATION	FY 2006 AMOUNT AUTHORIZED	FY 2006 BUDGET REQUEST
Infectious Diseases:				
Infectious Disease Control	Indefinite	\$225,589	Indefinite	\$224,761
PHSA §§ 301, 307, 310, 311, 317 ³ , 317N ³ , 317S ⁵ , 319, 319E ⁴ , 319F ⁴ , 319G ⁴ , 322, 325, 327, 352, 361-369, 1102 Immigration and Nationality Act §§ 212, 232				
HIV/AIDS, STD and TB Prevention	Indefinite	\$960,711	Indefinite	\$956,283
PHSA §§ 301, 307, 308(d), 310, 311, 317 ³ , 317E ¹ , 318 ¹ , 318A ¹ , 318B ³ , 327, 352, 2315, 2317, 2320, 2341, 2625 ³ , 2631 ³ Provisions Concerning Pregnancy and Perinatal Transmission of HIV [2625(c)] ⁴ Sexually transmitted diseases: Grants: PHSA §§ 318 ¹ , 318A ¹ Prevention Activities: PHSA §§ 301, 307, 310, 311, 317(a) ³ , 317P, 322, 327 Tuskegee Health Benefits: P.L. 103-333 Ryan White CARE Act Amendments § 502 of P.L. 106-345 International authorities: P.L. 107-116 sec. 215 Tuberculosis grants: PHSA § 317E ¹ National Information Programs ¹				
Immunization (Proposed Law)	Indefinite	\$479,029	Indefinite	\$428,714
Grants: PHSA §§ 317 (a), 317(j), 317(k)(1) Prevention Activities: PHSA §§ 301, 307, 310, 311, 317 ³ , 327, 340C, 352, 2125, 2126 Title XXI, Subtitle 1—National Vaccine Program § 1928 of Social Security Act (42 U.S.C. § 1396s)				
Health Promotion:				
Birth Defects/Developmental Disabilities/Disabilities & Health	Indefinite	\$124,576	Indefinite	\$123,563
PHSA §§ 301, 307, 310, 311, 317 ³ , 317C ¹ , 317J ³ , 327, 352, 1102				
Chronic Disease Prevention and Health Promotion	Indefinite	\$899,457	Indefinite	\$840,858
General Authority: PHSA §§ 301, 307, 310, 311, 317 ³ , 317K ³ , 327, 340D, 352, 391, 1102, 1501-1510 ¹ , 1706 ¹ Public Health Cigarette Smoking Act of 1969 Comprehensive Smoking Education Act of 1984 Comprehensive Smokeless Tobacco Health Education Act of 1986 Fertility Clinic Success Rate and Certification Act of 1992 Prostate cancer: PHSA § 317D ² Cancer registries: PHSA §§ 399B-399D ² , 399F ² Diabetes Among Children and Youth: PHSA § 317H ³ Safe Motherhood/Infant Health Promotion: PHSA §§ 317K(a) ³ , 317K(b) ³ , 317L ³ Childhood Obesity Prevention PHSA §§ 399W-399Z ³ Oral Health Promotion: PHSA § 317M ³ Prevention centers: PHSA §§ 301, 310, 311, 317 ³ , 391, 1102, 1706 ¹				

DOLLARS IN THOUSANDS	FY 2005 AMOUNT AUTHORIZED	FY 2005 APPROPRIATION	FY 2006 AMOUNT AUTHORIZED	FY 2006 BUDGET REQUEST
Supplemental Grants for Preventive Health Services (WISEWOMAN): 1509 ¹ Hematological Cancer Research Investment and Education: 419C Breast and cervical cancer prevention: PHSA §§ 301, 340D, 1501-1510 ¹ Breast and Cervical Cancer Mortality Prevention Act				
Health Information and Service:				
Health Statistics	Indefinite	\$109,021	Indefinite	\$109,021
PHSA §§ 301, 304, 306 ¹ 307, 308 1% Evaluation: PHSA § 241 (non-add) (Superceded in the FY 2002 Labor HHS Appropriations Act - Section 206)	Not more than 1.25% of amounts appropriated for PHSA programs as determined by the Secretary		Not more than 1.25% of amounts appropriated for PHSA programs as determined by the Secretary	
Public Health Informatics and Health Marketing	Indefinite	\$119,652	Indefinite	\$114,778
PHSA §§ 301, 304, 306, 308, 307, 310, 311, 317 ³ , 318 ¹ , 319, 319A ⁴ , 319B ¹ , 319C ⁴ , 327, 352, 391, 1102, 2315, 2341 Clinical Laboratory Improvement Amendments of 1988, § 4				
Environmental Health and Injury:				
Environmental Health:	Indefinite	\$147,484	Indefinite	\$146,888
PHSA §§ 301, 307, 310, 311, 317 ³ , 317A ³ , 317B, 317I ³ , 327, 352, 1102 Housing and Community Development Act, 1021 (15 U.S.C. 2685)				
Injury Prevention and Control:	Indefinite	\$138,237	Indefinite	\$137,931
PHSA §§ 301, 307, 310, 311, 317 ³ , 327, 352, 391-394A ³ Use of Allotments for Rape Prevention Education (393B) ³ Sec 318 of the Family Violence Prevention and Services Act (42 U.S.C. 10418) ⁶ P.L. 106-174 (42 U.S.C 14801) – the Poison Control Center Enhancement and Awareness Act ⁷				
Occupational Safety and Health:				
Occupational Safety and Health	Indefinite	\$286,041	Indefinite	\$285,930
PHSA §§ 301, 304, 306 ¹ , 308, 310, 311, 317 ³ , 317A ³ , 317B, 327 Occupational Safety and Health Act of 1970 (P.L. 91-596), §§ 20-22 Federal Mine Safety and Health Act of 1977, P.L. 91-173 as amended by P.L. 95-164, §§ 101, 102, 103, 202, 203,204, 205, 206, 301, 501, 502, 508 Federal Fire Prevention and Control Act, § 209, (29U.S.C.671(a)) Radiation Exposure Compensation Act, §§ 6 and 12(42U.S.C.2210)				

DOLLARS IN THOUSANDS	FY 2005 AMOUNT AUTHORIZED	FY 2005 APPROPRIATION	FY 2006 AMOUNT AUTHORIZED	FY 2006 BUDGET REQUEST
Housing and Community Development Act of 1922 §1021 (15 U.S.C. 2685) Floyd D. Spence National Defense Authorization Act §§ 3611, 3612, 3623, 3624, 3625, 3626 of P.L. 106-393				
Global Health:				
Global Health	Indefinite	\$293,863	Indefinite	\$306,079
PHSA §§301, 304, 307, 310, 319, 327, 340C, 2315, 2341 International authorities: P.L. 107-116 sec. 215				
Public Health Research:				
Public Health Research	Indefinite	\$31,000	Indefinite	\$31,000
PHSA §§ 301, 304, 307, 310, 317, 327	Not more than 1.25% of amounts appropriated for PHSA programs as determined by the Secretary		Not more than 1.25% of amounts appropriated for PHSA programs as determined by the Secretary	
Public Health Improvement and Leadership:				
Public Health Improvement:	Indefinite	\$266,843	Indefinite	\$206,541
PHSA §§ 301, 304, 307, 310, 311, 317 ³ , 317F ¹ 318 ¹ , 319, 319A ⁴ , 319B ¹ , 319C ⁴ , 327,352, 361, 362, 368,391, 399F ¹ 1102, 2315, 2341 Federal Technology Transfer Act of 1986, (15 U.S.C. 3710) Bayh-Dole Act of 1980, P.L. 96-517 Clinical Laboratory Improvement Amendments of 1988, § 4				
Preventive Health and Health Services Block Grant:				
Preventive Health and Health Services Block Grant	Indefinite	\$130,759	Indefinite	\$0
Grants: PHSA Title XIX ¹ Prevention Activities: PHSA §§ 214, 301, 304, 306 ¹ , 307, 308, 310, 311, 317 ³ , 327				
Buildings and Facilities:				
Buildings and Facilities	Indefinite	\$269,708	Indefinite	\$30,000
PHSA §§ 319D ⁸ , 321(a)				
Business Services Support:				
Business Services Support	Indefinite	\$278,840	Indefinite	\$263,715
PHSA §§ 301, 304, 307, 310, 317 ³ , 317F ¹ , 319, 327, 361, 362, 368, 399F ¹ Federal Technology Transfer Act of 1986, (15 U.S.C. 3710) Bayh-Dole Act of 1980, P.L. 96-517				
ATSDR: (non-add)				
ATSDR	Indefinite	\$76,041	Indefinite	\$76,024
Comprehensive Environmental Response, Compensation, and Liability Act § 104(l)				

DOLLARS IN THOUSANDS	FY 2005 AMOUNT AUTHORIZED	FY 2005 APPROPRIATION	FY 2006 AMOUNT AUTHORIZED	FY 2006 BUDGET REQUEST
Resource Conservation and Recovery Act § 3001 Great Lakes Critical Programs Act of 1990 Clean Air Act of 1990 Housing and Community Development (Lead Abatement) Act of 1992				
Terrorism: (non-add)				
Terrorism	Indefinite	\$1,560,445	Indefinite	\$1,616,723
PHSA §§ 301, 307, 311, 317 ³ , 319, 319A ⁴ , 319D ⁴ , 319F ⁴ , 319G ⁴ , 361-368 (42 U.S.C. 262 note), 2801-2811				
Reimbursables: (non-add)				
PHSA §§ 301, 306(b)(4), 353 Clinical Laboratory Improvement Act User fee: Labor-HHS FY Appropriations	Indefinite		Indefinite	
Total Appropriation –Proposed Law		\$4,760,811		\$4,206,063

*CDC is still in the process of crosswalking the new organizational structure to the old organizational structure; therefore, placement of the authorizing legislation will not be finalized until the FY 2007 budget process.

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

EXHIBIT M. APPROPRIATIONS HISTORY TABLE

CENTERS FOR DISEASE CONTROL AND PREVENTION¹				
APPROPRIATION HISTORY TABLE				
DISEASE CONTROL, RESEARCH, AND TRAINING				
	Estimate	House Allowance	Senate Allowance	Appropriation
1997	2,229,900,000	2,187,018,000	2,209,950,000	2,302,168,000 ²
1998	2,316,317,000 ³	2,388,737,000	2,368,133,000	2,374,625,000 ⁴
1998 Supplemental	--	--	--	9,000,000 ⁵
1999	2,457,197,000	2,591,433,000	2,366,644,000 ⁶	2,609,520,000 ⁷
1999 Offset	--	--	--	(2,800,000) ⁸
1999 Resc./1% Transfer	--	--	--	(3,539,000)
2000	2,855,440,000 ⁹	2,810,476,000	2,802,838,000	2,961,761,000 ¹⁰
2000 Rescission	--	--	--	(16,810,000)
2001	3,239,487,000	3,290,369,000	3,204,496,000	3,868,027,000
2001 Rescission	--	--	--	(2,317,000)
2001 Sec's 1% Transfer	--	--	--	(2,936,000)
2002	3,878,530,000	4,077,060,000	4,418,910,000	4,293,151,000 ¹¹
2002 Rescission	--	--	--	(1,894,000)
2002 Rescission	--	--	--	(2,698,000)
2003	4,066,315,000	4,288,857,000	4,387,249,000	4,296,566,000
2003 Rescission	--	--	--	(27,927,000)
2003 Supplemental ¹²	--	--	--	16,000,000
2004 ¹³	4,157,330,000	4,538,689,000	4,494,496,000	4,367,165,000
2005 ¹³	4,213,553,000	4,228,778,000	4,538,592,000	4,533,910,000
2005 Labor/HHS Reduction	--	--	--	(1,944,000)
2005 Rescission	--	--	--	(36,256,000)
2006 ¹³	3,940,963,000	--	--	--

¹Does not include funding for ATSDR and Bioterrorism

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

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

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

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

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

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

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

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

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

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

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

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

Centers for Disease Control and Prevention				
Appropriation History Table				
Terrorism Funding				
	FY 2006 Estimate	House Allowance	Senate Allowance	FY 2005 Appropriation
1999	---	43,000,000 ¹	81,000,000	123,600,000
2000	118,000,000	138,000,000	189,000,000	155,000,000
2000 Rescission	---	---	---	(320,000)
2001	148,500,000	182,000,000	148,500,000	180,919,000
2002	181,919,000	231,919,000	181,919,000	181,919,000
2002 PHSSEF ⁴				2,070,000,000
2002 Rescission ³	--	--	--	(396,000)
2003 ⁴	1,116,740,000	1,522,940,000	1,536,740,000	--
2003 Transfer ²	(400,000,000)	--	--	--
2004 ⁴	1,116,156,000	1,116,156,000	1,116,156,000	1,507,211,000
2004 Transfer ²	(400,584,000)	--	--	--
2005	1,509,571,000	1,637,760,000	1,639,571,000	1,573,300,000
2005 Labor/HHS Reduction				(271,000)
2005 Rescission				(12,584,000)
2006	1,616,723,000			

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

²Public Health and Social Services Emergency Fund

³Administrative and Related Expenses Reduction.

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

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

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

NARRATIVE JUSTIFICATIONS

INFECTIOUS DISEASES

Infectious Diseases (Dollars in Thousands)	FY 2004 Actual	FY 2005 Enacted	FY 2006 Estimate*	FY 2006 +/- FY 2005
BA	\$1,641,600	\$1,652,536	\$1,596,964	(\$55,571)
PHS Evaluation Transfers	\$12,794	\$12,794	\$12,794	\$0
Total	\$1,654,394	\$1,665,330	\$1,609,758	(\$55,571)
FTE	2,337	2,357	2,354	(3)

*The FY 2006 budget request reflects the Proposed Law transfer of \$100 million from the discretionary Section 317 Program to the mandatory Vaccines For Children program.

INTRODUCTION

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

CDC's Infectious Diseases activities include responsibilities for:

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

By unifying infectious disease activities, management, communications, strategy, science, program integration, and workforce and career development will be coordinated for all of these activities. Full implementation of these coordinating functions in FY 2006 will ensure infectious disease programs are based on the highest standards of quality, equity, and integrity as well as ensuring excellent service to CDC's customers.

INFECTIOUS DISEASES CONTROL

AUTHORIZING LEGISLATION

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

Infectious Diseases Control (Dollars in Thousands)	FY 2004 Actual	FY 2005 Enacted	FY 2006 Estimate	FY 2006 +/- FY 2005
BA	\$221,729	\$225,589	\$224,761	(\$829)

STATEMENT OF THE BUDGET

The FY 2006 budget request of \$224,761,000 for Infectious Diseases Control represents a decrease of \$829,000 below the FY 2005 Enacted level of \$225,589,000.

PROGRAM DESCRIPTION

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

Infectious disease outbreaks can have huge medical and economic consequences. In the U.S. alone, an influenza pandemic could cause an estimated 89,000 – 207,000 deaths, and 314,000 – 734,000 hospitalizations. In addition, the economic impact would range from \$71 – \$167 billion. With the recent widespread outbreaks of avian influenza in poultry in Asia and 34 reported human deaths due to infections with avian A(H5N1) influenza, we must be vigilant in our surveillance for avian viruses that may adapt and become easily transmissible in humans. Each year, 76 million U.S. citizens suffer from foodborne illnesses; 325,000 are hospitalized, about 5,000 die, and the economic burden is estimated to be greater than \$6 billion. The prevention and control of emerging microbial threats are fundamental to individual, national, and global health and security.

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

Funding for Infectious Disease Control for the last five years:

FY	FUNDING*
2001	\$317,582,000
2002	\$348,181,000
2003	\$359,225,000
2004	\$221,729,000
2005	\$225,589,000

*FY 2004 and FY 2005 funding levels reflect the removal of management and administrative costs under the new budget structure. FY 2001-2003 funding levels are not available in the new structure and include management and administrative costs.

PERFORMANCE ANALYSIS

The following activities and accomplishments include efforts to address hepatitis C, influenza, foodborne illness, group B streptococcal infections, antimicrobial resistance, and reducing the burden of illness from infectious diseases among hospitalized patients and healthcare workers, as well as other activities.

PROTECT AMERICANS FROM INFECTIOUS DISEASES

CDC tracks its infectious disease efforts by monitoring performance in key areas that contribute to high mortality, morbidity, or healthcare costs and where there are opportunities for prevention and control: hepatitis and chronic liver disease, influenza, foodborne illnesses, and group B streptococcal infections; finding solutions to the problems posed by antimicrobial resistance; and reducing the burden of illness from infectious diseases among hospitalized patients and health care workers (see GPRAs goals and measures on subsequent pages).

GOAL: PROTECT AMERICANS FROM INFECTIOUS DISEASES – HEPATITIS C, CHRONIC LIVER DISEASE AND VIRAL HEPATITIS.

CDC provides leadership and coordination for the prevention, control, and elimination of hepatitis virus infections, and their acute and chronic liver disease consequences, both in the U.S. and internationally. Hepatitis C virus (HCV) infection is the most common chronic bloodborne viral infection in the U.S. Approximately 2.7 million people in the U.S. are chronically infected with HCV and most of them are not aware of their infections and are not clinically ill.

Cirrhosis of the liver develops in ten to twenty percent of people with chronic hepatitis C over a period of twenty to thirty years, and liver cancer develops in one percent to five percent. Chronic liver disease is the tenth leading cause of death among adults in the U.S. An estimated 40 percent to 60 percent of chronic liver disease is due to hepatitis C.

Current Activities

- Educating healthcare and public health professionals to improve identification of persons at risk for chronic HCV infection; and ensuring appropriate counseling, diagnosis, management, and treatment.
- Educating the public and persons at risk about risk factors and the need for chronic Hepatitis B virus (HBV) and HCV infections and the need for testing and evaluation.
- Promoting clinical and public health activities aimed at identifying, counseling, and testing persons at risk for chronic HBV and HCV infection and evaluating or referring persons found to be infected.
- Continuing efforts to implement hepatitis A and B vaccination programs.
- Strengthening surveillance to monitor disease trends and identify missed opportunities for vaccination.
- Continuing to evaluate the implementation, effectiveness, and impact of current prevention strategies.
- Conducting studies to determine hepatitis A vaccination coverage among children living in parts of the country in which routine hepatitis A vaccination is recommended, to determine the extent to which declines in hepatitis A incidence can be ascribed to vaccination, and to identify gaps in immunization coverage.
- Conducting studies to identify persons with chronic HBV and HCV infections and to estimate disease burden from viral hepatitis and chronic liver disease.
- Evaluating the delivery of viral hepatitis prevention counseling and testing, referral, and education in STD, HIV, drug treatment, and correctional health care settings.
- Conducting a study to determine the frequency of: 1) recognized episodes of possible HBV or HCV transmission in health care settings, including outpatient clinics and private medical practices, and 2) reports of infection control lapses that have the potential to transmit viral hepatitis.
- Conducting studies to evaluate the long-term protection afforded by hepatitis B vaccination among Alaska Natives.
- Conducting a nationwide survey of health-care facilities to assess the prevention of HBV transmission, specifically assessing hepatitis B vaccination levels among health care workers and facility policies concerning hepatitis B testing and vaccination of employees.

Significant Accomplishments

- Supported HCV coordinators in 48 states and three large metropolitan areas to integrate viral hepatitis counseling, testing, referral, and surveillance into existing public health programs.
- Demonstrated the feasibility of hepatitis B vaccine delivery and 70 – 95 percent first dose acceptance among high-risk adults in community-based demonstration projects in multiple settings, including STD clinics, HIV testing and counseling sites, and correctional facilities.
- Funded the development in five additional states of state-based hepatitis C and viral hepatitis prevention plans, for a total of twenty-eight plans developed.
- Distributed a Hepatitis C Toolkit, including physician and patient educational material, to more than 150,000 physicians in 26 states.
- Supported 12 non-governmental organizations to develop and disseminate hepatitis information and educational materials to the general public and groups at high risk of infection.
- Dramatically reduced the number of both acute hepatitis A cases in the United States overall, and eliminated racial/ethnic infection rate disparities, through the continued implementation of immunization program activities.

GOAL: PROTECT AMERICANS FROM INFECTIOUS DISEASES – INFLUENZA.

Collecting data domestically and internationally is essential for early detection of an influenza pandemic and effective tracking of its spread. In addition, international data provide critical information needed to improve vaccine decision-making. Maintaining and improving the sentinel physician surveillance system is a priority because it is the primary U.S. system for measuring illness due to influenza and is a source of specimens necessary for monitoring circulating viruses in the U.S. Data collected about circulating influenza viruses are used to form the basis of annual vaccine decisions. The sentinel physician surveillance system is the primary system for early detection of influenza activity in communities and tracking of the impact of influenza on both a local and national level during regular influenza seasons as well as during a pandemic.

Current Activities

- Conducting worldwide monitoring of influenza viruses to collect data that contributes to annual Northern and Southern hemisphere vaccine decisions.
- Building capacity domestically and internationally to improve systems for early detection of unusual increases in influenza activity and new influenza viruses.
- Working with state health departments to improve vaccine delivery.
- Conducting research aimed at developing rapid molecular methods for characterizing novel influenza viruses.

Significant Accomplishments

- Participated in an interagency working group that developed the U.S. pandemic preparedness plan for final review by HHS and posting for public comment.
- Strengthened the international network of collaborating laboratories to monitor the emergence and spread of new epidemic and pandemic strains of influenza.
- Provided onsite technical assistance and/or training to China, Vietnam, Thailand and Malaysia for the avian influenza outbreak, and technical assistance to South Korea and Taiwan through training at CDC.
- Provided support for influenza surveillance in Asia, Europe and Latin America to monitor for variant viruses that could circulate in the U.S. in the future.
- Conducted workshops for both influenza surveillance and state pandemic planning. Additionally, CDC conducted two trainings for states on modern methods for influenza detection and subtyping, with a focus on implementing molecular techniques for influenza surveillance.
- Conducted research aimed at developing rapid molecular methods for characterizing novel influenza viruses and the human antibody response.
- Developed rapid methods to screen viruses for antiviral resistance.

- Implemented a multi-faceted program to enhance influenza surveillance in Asia through: provision of bilateral cooperative agreements to nine countries affected by avian influenza for development of surveillance networks; strategic placement of HHS staff in WHO offices; and capitalizing on infrastructure in place to conduct more in depth studies on the impact of influenza and at the animal/human interface by providing support through interagency agreements for Department of Defense (DOD) in Indonesia and support to the International Emerging Infections Program in Thailand.

GOAL: PROTECT AMERICANS FROM INFECTIOUS DISEASES – FOODBORNE ILLNESSES.

As the lead Federal Agency for foodborne disease surveillance, CDC monitors occurrences of foodborne disease illnesses in the U.S. These surveillance systems provide early warning of dangers in the food supply, provide data on new or changing patterns of foodborne diseases, track progress of current prevention efforts, and provide information for development of new prevention strategies. CDC works extensively with state and local health departments to build their epidemiology, laboratory, and environmental health capacities for foodborne disease surveillance and outbreak response. CDC also works closely with federal food safety regulatory agencies to identify and evaluate foodborne disease prevention strategies.

Current Activities

- Detecting, investigating, and monitoring emerging foodborne pathogens, the diseases they cause, and the factors influencing their emergence.
- Assisting state and local health departments in response to unique and multi-state foodborne disease outbreaks.
- Providing assistance to 57 state and local health departments to build capacity to detect and respond to foodborne disease outbreaks through technology transfer, training, and financial resources.
- Advancing laboratory diagnostics and expanding laboratory networks for foodborne bacteria, viruses, parasites, and other contaminants.
- Improving integration of laboratory science and epidemiology resources to optimize public health practices for the prevention and control of food-related illnesses.
- Disseminating public health information about foodborne illnesses to physicians and the public.

Significant Accomplishments

- Established FoodNet, a network of ten sites around the U.S. that covers nearly 42 million persons and provides the most comprehensive information available on foodborne illness. FoodNet has demonstrated that infections with E.Coli 0157 have declined 42% since 1996, Campylobacter by 28%, and Salmonella by 17%.
- Implemented PulseNet, an early warning system for foodborne illness outbreaks, in all 50 states. Pulse Net detects outbreaks earlier by performing near real-time comparison of disease-causing bacteria isolated from people, even if they are geographically far apart. Provided training and protocols to Latin American countries interested in joining PulseNet Latin America, and for Asian and Pacific countries joining PulseNet Asia/Pacific Rim, and consulted with European colleagues forming PulseNet Europe.
- Expanded laboratory technologies for rapid detection of food-borne outbreaks caused by viral pathogens.
- Developed and implemented a state-of-the-art diagnostic and communications system known as DPDx to improve parasitic disease diagnoses in the U.S.
- Conducted an investigation into a large multi-state outbreak of salmonellosis, of more than 500 cases, tracing the outbreak to sliced tomatoes. Tomatoes were removed swiftly from the source delis, stopping the outbreak.
- Investigated an outbreak of hepatitis A in Tennessee, North Carolina, Georgia, and Pennsylvania, and successfully traced the outbreak to green onions imported from Mexico, which resulted in an import ban by the FDA.
- Developed and implemented a foodborne disease training course for local public health officials; more than 300 officials from 29 states have been trained thus far and more courses are scheduled.

GOAL: PROTECT AMERICANS FROM INFECTIOUS DISEASE – GROUP B STREPTOCOCCAL INFECTIONS.

Group B streptococcus (group B strep) is a type of bacteria that causes illness in newborn babies, pregnant women, the elderly, and adults with other illnesses, such as diabetes or liver disease. Group B strep is the most common cause of life-threatening infections in newborns. CDC's group B strep mission is to monitor the burden of disease through active surveillance and to motivate, support, and evaluate efforts to prevent maternal and newborn group B streptococcal infections in the U.S. and globally.

Current Activities

- Evaluating the impact and effectiveness of current prevention strategies.
- Assessing unintended consequences of antibiotic prevention strategies including emerging drug resistance, changes in other causes of newborn sepsis, and shortages of specific antimicrobial agents.
- Collaborating with 11 states in the Active Bacterial Core Surveillance (ABCs)/Emerging Infections Program network and elsewhere to monitor compliance with prevention recommendations.
- Raising awareness about group B strep disease prevention recommendations among the following target audiences: health care providers/hospitals/HMOs, clinical laboratory personnel, state and local public health partners, and the general public including members of high risk minority populations.
- Establishing isolate archive and measuring strain characteristics (e.g. 'types') to guide vaccine development.
- Evaluating the preventive effectiveness of topical disinfectant in labor as a non-antibiotic requiring means of interrupting mother-to-child spread of group B streptococci and other causes of newborn sepsis.

Significant Accomplishments

- Established the ABCs system, currently operating in ten U.S. states, to monitor the burden of invasive group B streptococcal disease.
- Developed guidelines and revised recommendations for the prevention of perinatal group B streptococcal disease, resulting in a 70 percent reduction in disease since 1993 in the U.S.
- Documented a further 34% decrease in group B streptococcal disease one year after universal screening guidelines went into effect; achieved healthy people 2010 target in whites, approaching target in African-Americans.
- Documented increased resistance to key drugs among group B streptococcal bacteria, requiring changes in alternative drugs recommended for women with penicillin allergy.
- Demonstrated 3- to 5-valent vaccines under research development for group B strep will cover the vast majority of circulating strains of the organism.
- Launched a randomized controlled trial in South Africa measuring protective effectiveness of topical disinfectant during childbirth on clinical sepsis and vertical transmission of group B strep and other key indicator bacteria.
- Documented the narrowing of racial disparities; black-white gap in newborn infections has narrowed by 68% since 1993. Despite improvement, blacks have 2.2 times higher risk of early group B strep infection.
- Produced and distributed consumer educational information targeted at African-American women based on formative research in this high risk population.

ANTIMICROBIAL RESISTANCE

GOAL: REDUCE THE SPREAD OF ANTIMICROBIAL RESISTANCE.

Antimicrobial resistance is a growing concern around the world. Many important human infections are developing resistance to the antimicrobial drugs used to treat them. In the 1970s, virtually all *Streptococcus pneumoniae*, an organism which is a common cause of ear infections, meningitis, and pneumonia were susceptible to preferred drugs. Today however, up to 34% found in some areas of the U.S. are no longer susceptible to penicillin, and multidrug resistance is common. *Staphylococcus aureus* is a common cause of skin and more serious infections and over 60% of infections acquired in U.S. intensive care units are now resistant to the preferred methicillin class drugs. In the late 1980s, large outbreaks of multidrug-resistant TB occurred in several hospitals in the U.S. and many patients died. Multidrug-resistant TB must be treated for 2 years or more and costs as much as \$100,000 per patient to treat. The prevalence of fluoroquinolone resistant *Neisseria gonorrhoeae* has increased from less than 2% in 2001 to 15% in

2003 among men who have sex with men infected with gonorrhea. Some infections found among hospitalized patients are resistant to virtually all effective antimicrobial drugs available. Resistance to the most effective antimicrobial drugs can require treatment with less effective and more expensive alternatives which may also be associated with a greater risk for side effects.

In 1999, CDC, FDA, and the NIH co-chaired a task force to better coordinate public health efforts to address antimicrobial resistance. Since 2001, the agencies have been implementing the task force's action plan. Priority actions for CDC include: (1) monitoring drug resistance and use, (2) educating the public and clinicians about drug prescribing, and (3) improving infection control practices in healthcare settings and elsewhere and (4) preventing drug-resistant infections from being imported into the U.S.

Current Activities

- Supporting state and local health departments to improve monitoring and tracking of drug-resistant infections and drug-prescribing practices and to promote appropriate antibiotic use.
- Translating research findings into community-based and healthcare-based prevention programs to promote appropriate antimicrobial use, infection control, vaccine use, and detection of drug-resistant infections.
- Developing laboratory tests to detect drug resistance, studying the molecular basis of resistance, and evaluating interventions, such as improved prescribing and infection control practices.

Significant Accomplishments

- Recommendations for use of pneumococcal vaccine have led to a dramatic decline in serious disease such as meningitis due to resistant pneumococci. NCID's Emerging Infections Program/Active Bacterial Core Surveillance estimates that such infections have dropped by half.
- Supported multifaceted interventions for clinicians and patients by 28 state health departments to promote the appropriate use of antibiotics for outpatient upper respiratory infections.
- Improved appropriate use of antimicrobials in the U.S. through the public health campaign, "Get Smart: Know When Antibiotics Work."
- Developed and implemented "Campaign to Prevent Antimicrobial Resistance in Healthcare Settings" which focuses on providing evidence-based methods for preventing antimicrobial resistance among specific patient populations.
- In 2004, awarded over \$3.5 million in 14 grants to academic institutions for applied research on antimicrobial resistance.
- Produced and distributed a CD-ROM to train clinical microbiology laboratory personnel on standardized testing methods for antimicrobial resistance.
- Created the Multilevel Antimicrobial Susceptibility Testing Educational Resource (M.A.S.T.E.R.) Program web site which provides up-to-date information on resistance testing methods.

MEDICAL ERRORS AND HEALTHCARE-ASSOCIATED INFECTIONS

GOAL: PROTECT AMERICANS FROM DEATH AND SERIOUS HARM CAUSED BY MEDICAL ERRORS AND PREVENTABLE IMPLICATIONS OF HEALTHCARE.

Assuring the safety of patients receiving health care is a public health priority. According to a sentinel IOM report on patient safety, an estimated 44,000 to 98,000 Americans die each year from preventable medical errors. Wound infections are the second leading type of preventable adverse events.

Patient safety funding is being used primarily for enhancements in the measurement and intervention capacity to prevent medical errors and other adverse health events. The National Healthcare Safety Network (NHSN), a national program that not only measures, but also provides interactive capacity to intervene through health communications campaigns and a targeted intervention program, is underway.

Current Activities

- Continuing the development of the National Healthcare Safety Network (NHSN).
- Collaborating with healthcare providers in Chicago to reduce antibiotic prescribing errors and complications of therapy by utilizing electronic data warehouse for the detection and remediation of redundant antimicrobial prescribing, unnecessary vancomycin use, and other prescribing errors.

Significant Accomplishments

- Collaboration with healthcare providers and sponsoring organizations in Southwestern Pennsylvania (Pittsburgh Regional Healthcare Initiative) resulted in a 55% region-wide decline in central line-associated blood stream infections.
- Bloodstream infection rates were reduced by over 18% total in the 13 Prevention Epicenters that participated in an educational intervention to prevent catheter-associated bloodstream infections.
- Demonstrated an association between improved hand hygiene and a decrease in inappropriate use of antimicrobials with a decrease in infections caused by antimicrobial resistant bacteria.

OTHER NATIONAL AND INTERNATIONAL INFECTIOUS DISEASE ACTIVITIES AND ACCOMPLISHMENTS

CDC engages in and tracks a variety of infectious disease activities both domestically and globally that are not reflected in its performance plan. These activities encompass priority public health areas of surveillance and response, research, capacity building and prevention and control efforts. CDC works to rapidly improve the ability to recognize and intervene in newly identified conditions before they become significant problems within the U.S. CDC is also continuing its global efforts to build a comprehensive global disease detection and response system.

Current Activities

- Funded five academic institutions totaling \$3.5 million for research on Lyme disease. The number of Lyme disease cases reported in the United States has increased from 9,470 cases in 1991, the first year of national surveillance, to 21,273 in 2003, despite federal, state, and local efforts to prevent the disease.
- Funded academic institutions to conduct research on the transmission of hantavirus. The hantavirus causes a condition known as hantavirus pulmonary syndrome (HPS) that progresses rapidly and can lead to death.
- Continued to build epidemiology and laboratory capacity in the U.S. by providing funds and technical assistance to 58 state, territorial, and local health departments. The funds are used to enhance national capacity to identify and monitor the occurrence of known infectious diseases of public health importance, detect new and emerging infectious disease threats, respond to disease outbreaks, and use public health data for priority setting.
- Continued training young scientists in public health laboratory practice as part of the Emerging Infectious Diseases Laboratory fellowship. Since its inception in 1995, 228 scientists have participated in the program. Of the 173 who have completed the program as of December 2003, 76 (44%) have pursued continuing education and 52 (30%) have accepted positions in public health laboratories at CDC or within state or local health departments.

Significant Accomplishments

- Deployed teams of experts to provide technical assistance to outbreaks of SARS, Hepatitis A, and avian influenza in Vietnam.
- Established domestic and global sentinel surveillance networks linking health care providers in order to improve the ability to detect and monitor emerging diseases, including networks (1) along the U.S.-Mexico border; (2) among sentinel physicians for influenza; (3) of travel medicine clinics in the U.S. and other countries; (4) of academic hospital emergency departments; and (5) among infectious disease specialists throughout the U.S. These networks are uniquely capable of identifying and responding to newly emerging infections that require immediate attention.
- Established 11 population-based Emerging Infections Programs (EIPs) in the U.S. to investigate emerging diseases. Much of the activity in the EIP network involves collaborative projects including: population-based surveillance for invasive bacterial pathogens including drug resistant pathogens; a population-based active surveillance network (FoodNet) to develop and evaluate food-borne disease prevention and control strategies; and systematic investigations to determine the causes of unexplained deaths and serious illness in the U.S.
- Enhanced surveillance for prion diseases in the U.S. including increased support for special surveillance and laboratory studies focused on person-to-person transmission of variant Creutzfeldt - Jakob disease and Creutzfeldt - Jakob disease (vCJD and CJD) through plasma derivatives and blood transfusions, respectively.

NARRATIVE JUSTIFICATIONS
INFECTIOUS DISEASES
INFECTIOUS DISEASES CONTROL

- Developed and implemented, with other federal, private, and commercial partners, strategies and protocols that resulted in programs screening the entire U.S. blood supply for WNV contamination beginning in 2003. Since screening began, 1016 presumptively viremic donors have been reported to CDC.

RATIONALE FOR THE BUDGET

The FY 2006 budget request of \$224,761,000 for Infectious Diseases Control represents a decrease of \$829,000 below the FY 2005 Enacted level of \$225,589,000. This includes the restoration of an FY 2005 Labor/HHS/Education reduction of \$111,000.

IT REDUCTION

Funding for the Infectious Diseases Control activity includes an information technology savings of \$940,000.

OUTPUT TABLE

OUTPUT TABLE	FY 2004 ACTUAL	FY 2005 APPROPRIATION	FY 2006 ESTIMATE	FY 2006 +/- FY 2005
Number of domestic and global surveillance networks for emerging diseases including respiratory syndromes	8	8	8	0
Number of hepatitis C coordinators in state and local health departments	51	51	51	0
Number of EIP network sites	11	11	11	0
Number of national surveillance and response programs in states and large local health departments for West Nile and other arboviruses	58	58	58	0
Number of state/local health departments and healthcare systems supported for surveillance, prevention, and control of antimicrobial resistance	50	50	50	0
Number of extramural grants for antimicrobial resistance research to academic institutions and states	11	14	14	0
Number of reporting domestic sentinel physician sites to improve influenza surveillance	891	1000	1000	0
Number of state and local health departments supported to build epidemiological and laboratory capacity for influenza	47	47	47	0
Number of applied research projects funded to improve influenza vaccines	0	1	1	0
Number of sites in the National Healthcare Safety Network to report healthcare based reporting of adverse health events and errors	2	300	300	0
Food Safety				
Number of countries that have received PulseNet training and protocols	10	10	10	0
Number of active participants (public health laboratories) submitting patterns to PulseNet:				
a. E. coli O157:H7	45	45	45	0
b. Salmonella Typhimurium	45	45	45	0
c. Listeria monocytogenes	30	30	30	0
d. Shigella sonnei	15	15	15	0

NARRATIVE JUSTIFICATIONS
INFECTIOUS DISEASES
INFECTIOUS DISEASES CONTROL

OUTPUT TABLE		FY 2004 ACTUAL	FY 2005 APPROPRIATION	FY 2006 ESTIMATE	FY 2006 +/- FY 2005
e.	Clostridium perfringens	5	5	5	0
f.	Campylobacter jejuni/ C. coli	5	5	5	0
g.	Vibrio parahaemolyticus	5	5	5	0
h.	Vibrio cholerae	5	5	5	0
Number of public health laboratories capable of accessing CaliciNet to detect viral diseases		40	40	40	0
Number of public health laboratories using DPDx to detect parasitic diseases		41	41	41	0
Number of pathogens and syndromes under active surveillance in FoodNet sites		11	11	11	0
Number of states reporting food-borne disease data to CDC electronically		46	46	46	0

FUNCTIONAL TABLE

Infected Diseases Control Budget by Functional Activity (Dollars in Thousands)	FY 2004 Actual	FY 2005 Enacted	FY 2006 Estimate	FY 2006 +/- FY 2005
Infected Diseases	\$188,706	\$191,855	\$191,125	(\$730)
Food Safety	\$28,013	\$28,767	\$28,665	(\$101)
Chronic Fatigue Syndrome (CFS) Base	\$5,010	\$4,967	\$4,970	\$2
Total -	\$221,729	\$225,589	\$224,761	(\$829)

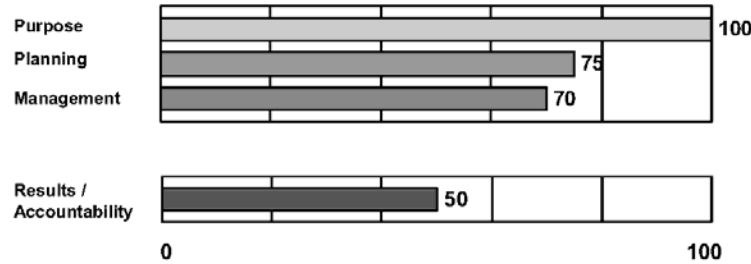
Chronic Fatigue Syndrome Budget by Functional Activity (Dollars in Thousands)	FY 2004 Actual	FY 2005 Enacted	FY 2006 Estimate	FY 2006 +/- FY 2005
CFS Base	\$5,010	\$4,967	\$4,970	\$2
National Centers for Infectious Disease Payback	\$309	\$2,401	\$0	(\$2,401)
Agency Payback ¹	\$0	\$1,355	\$0	(\$1,355)
Total CFS Funding -	\$5,319	\$8,723	\$4,970	(\$3,754)

¹CDC currently anticipates completion of the CFS payback in FY 2005.

Program: CDC: Infectious Diseases

Agency: Department of Health and Human Services

Bureau: Centers for Disease Control and Prevention



Key Performance Measures from Latest PART

	Year	Target	Actual
Long-term Measure: Meet targets for key foodborne pathogens, central line-associated bloodstream infections in ICU patients, invasive pneumococcal disease in children <5/adults >=65, and new cases of hepatitis A.	2002		2 of 4
	2003		3 of 4
	2010	4 of 4	
Annual Measure: Achieve reductions in the burden of illnesses or death attributed to infectious diseases, as measured by meeting 3 of 4 targets for key foodborne pathogens, the rate of central line-associated bloodstream infections in medical/surgical ICU patients, the rate of invasive pneumococcal disease in children under 5 years of age and in adults aged 65 years and older and the number of new cases of hepatitis A.	2002		2 of 4
	2006	3 of 4	
Annual Measure: The number of antibiotics prescribed for ear infections in children under 5 years of age per 100 children.	1997		69
	2002		63
	2006	60	
	2007	59	

Rating: Adequate

Program Type: Competitive Grant

Program Summary:

The Infectious Diseases program at the Centers for Disease Control and Prevention (CDC) works to prevent illness, disability and death caused by infectious diseases. The program is active in the United States and also works internationally to protect the US population from infectious and to minimize the impact of such diseases at their source.

The assessment found the Infectious Diseases program at CDC has a clear purpose and evidence of its impact on controlling disease, but can make improvements in program management and strategic planning. Details from the assessment include:

- The program has been the subject of multiple reports from the Government Accountability Office and has had targeted evaluations to help fill gaps in performance information. In general, these reports have highlighted areas of needed improvement but document the program's positive impact on controlling diseases.
- The program and agency are taking steps to improve financial management practices and accountability of Federal managers for program results.
- The program collaborates with a broad range of Federal, State, local and international partners to target resources and accomplish its mission.
- Through the assessment process the program adopted new long-term measures focused on food borne pathogens, bloodstream infections, pneumococcal disease and hepatitis A. The program will also measure progress in global influenza surveillance and detection as one key indicator of our preparedness for a pandemic influenza outbreak.

In response to these findings:

1. The program will track performance on the new long-term and annual performance measures this year. The program will also develop information on the performance of the Laboratory Response Network and its food borne illness tracking.
2. Over the next few years, the program will continue to identify areas to improve efficiency and cost effectiveness and document savings to demonstrate its improvement.
3. The program will enhance budget and performance integration to identify changes in program outcomes associated with resource levels.

Program Funding Level (in millions of dollars)

<u>2004 Actual</u>	<u>2005 Estimate</u>	<u>2006 Estimate</u>
222	226	225

PART RECOMMENDATIONS

The Infectious Diseases program was evaluated by PART during the FY 2006 budget cycle. Detailed information is provided below about the status of their PART recommendations.

RECOMMENDATION		COMPLETION DATE	ON TRACK? (Y/N)
Enhance budget and performance integration activities to identify changes in program outcomes associated with changes in funding level.		8/30/05	Y
COMMENT ON STATUS			
CDC identified the Division of Viral and Rickettsial Diseases (DVRD) to pilot budget planning using program outcomes to set funding priorities. In addition, CDC and DVRD are working BearingPoint to train Branch Chiefs, Team Leads, and Program Managers in measures development and goal setting.			
NEXT MILESTONE	NEXT MILESTONE DATE	LEAD ORGANIZATION	LEAD OFFICIAL
Implement/conduct pilot training.	2/28/05	CDC	Karen Long
Evaluate pilot training.	2/28/05	CDC	Karen Long

RECOMMENDATION		COMPLETION DATE	ON TRACK? (Y/N)
Hold Federal managers and program partners responsible for cost, schedule, and performance results.		On-going	Y
COMMENT ON STATUS			
Measurable outcomes have been added to SES employees, Distinguished Consultants, and SBRS/Title 42 Performance Plans.			
NEXT MILESTONE	NEXT MILESTONE DATE	LEAD ORGANIZATION	LEAD OFFICIAL
Include measurable outcomes in performance plans for Senior Executive Service employees.	On-going	CDC	Karen Long
Implement Performance Based Plans for Managers at the Division level beginning in January 2005.	1/31/05	CDC	Karen Long

NARRATIVE JUSTIFICATIONS
 INFECTIOUS DISEASES
 INFECTIOUS DISEASES CONTROL

RECOMMENDATION		COMPLETION DATE	ON TRACK? (Y/N)
Make grantee performance data available to the public in a more transparent and meaningful way.		On-going	Y
COMMENT ON STATUS			
<p>CDC implemented a web site that lists its Biodefense grantee's progress for Year 1 of their awards (http://www.cdc.gov/ncidod/oe/FY04_bioterrorism_accomplishments.htm). CDC plans to post performance data on the grantee profile pages, including FY 2004 funding, activities funded, links to the grantees home page, grantee contact information and FY 2004 Congressional summaries (available for a limited number of grantees). CDC is looking at how to update this information on an annual basis, and how to provide performance data that is meaningful to the public.</p> <p>CDC is currently updating its Epidemiologist Lab Capacity (ELC) conference on the Epi-X forum to provide a secure avenue for grantee PIs, program coordinators and CDC staff to learn about other grantees' programs, share information about their own programs and for CDC staff to provide general information. Members of the conference will be able to post messages, attach documents and read archives. Epi-X sends all members a daily notice of any postings to the ELC conference (http://www.cdc.gov/ncidod/osr/site/epi_lab/index.htm).</p>			
NEXT MILESTONE	NEXT MILESTONE DATE	LEAD ORGANIZATION	LEAD OFFICIAL
ELC will have the pilot website available for public use.	4/30/05	CDC	Karen Long

HIV/AIDS, STD AND TB PREVENTION

AUTHORIZING LEGISLATION

PHSA §§ 301, 307, 308(d), 310, 311, 3173, 317E1, 3181, 318A1, 318B3, 327, 352, 2315, 2317, 2320, 2341, 26253, 2631; Provisions Concerning Pregnancy and Perinatal Transmission of HIV [2625(c)]; Sexually transmitted diseases: Grants: PHSA §§ 3181, 318A; Prevention Activities: PHSA §§ 301, 307, 310, 311, 317(a)3, 317P, 322, 327; Tuskegee Health Benefits: P.L. 103-333; Ryan White CARE Act Amendments § 502 of P.L. 106-345; International authorities: P.L.108-447, sec.215; Tuberculosis grants: PHSA§317E; National Information Programs.

HIV/AIDS, STD and TB Prevention (Dollars in Thousands)	FY 2004 Actual	FY 2005 Enacted	FY 2006 Estimate	FY 2006 +/- FY 2005
BA	\$963,876	\$960,711	\$956,283	(\$4,428)

STATEMENT OF THE BUDGET

The FY 2006 budget request of \$956,283,000 for HIV/AIDS, STD and TB Prevention represents a decrease of \$4,428,000 below the FY 2005 Enacted level of \$960,711,000.

PROGRAM DESCRIPTION

Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS), sexually transmitted diseases (STDs), and tuberculosis (TB) are among the most prevalent infectious diseases in the U.S. and have a substantial impact globally as well. Approximately 900,000 Americans have been infected with HIV, the virus that causes AIDS, and an estimated 40,000 more are infected each year at an estimated lifetime cost of \$224,000 per person. One-quarter of those infected are unaware of their infection, yet persons who are aware of their infection are more likely to modify their behaviors to avoid transmission to others. Actual transmission is thought to be much higher than reported, as many infections are asymptomatic and undiagnosed. In the United States, an estimated 18.9 million new cases of STDs (excluding HIV) occur each year. Chlamydia, for example, is the most commonly reported infectious disease in the U.S. Yet, when diagnosed, chlamydia, gonorrhea, and syphilis are curable and transmission to others is preventable. TB afflicted over 14,000 Americans in 2003 and is a leading infectious cause of death worldwide, killing two million people in 2002, despite the availability of effective treatments and control programs.

Effective control of TB and STDs is necessary to protect the health of HIV-infected persons and to reduce HIV transmission. HIV infection disables the immune system, putting infected persons at higher risk for developing other infectious diseases. Care must be taken to avoid exposing HIV-infected persons to TB, and to treat those individuals who have been infected because HIV-infected persons who are also infected with TB have an 8-10 percent chance per year of developing active TB. Chlamydia and syphilis have been shown to increase the risk of HIV transmission among adults at least 3-5 fold. Preventing STDs, therefore, is one effective way to prevent the spread of HIV.

Although these diseases affect all Americans, they often hit hardest those populations that are least able to respond – the poor, minorities, youth, immigrants, incarcerated persons, and other disenfranchised populations. Syphilis remains one of the most glaring examples of racial disparities in health. The highest chlamydia and gonorrhea rates occur among adolescents and young adults. The HIV epidemic continues to have a disproportionate impact on racial and ethnic minorities. Studies of incarcerated persons have found that this group is often disproportionately impacted by a variety of health problems, particularly HIV, STDs, TB and substance abuse.

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

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

NARRATIVE JUSTIFICATIONS
INFECTIOUS DISEASES
HIV/AIDS, STD AND TB PREVENTION

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

To prevent STDs, CDC provides national leadership through research, surveillance, policy development, and assistance to states, territories, and local health departments in the delivery of services to prevent and control transmission and related complications of STDs. Comprehensive STD Prevention Systems (CSPS) grants provide federal support for a community-wide, science-based, interdisciplinary "systems" approach to STD prevention as recommended by the Institute of Medicine (IOM) in its 1997 report: *The Hidden Epidemic: Confronting Sexually Transmitted Diseases*. National surveillance of syphilis, chlamydia, and gonorrhea is supported and sentinel surveillance strategies have been developed for Human Papillomavirus (HPV). Prevention research is conducted to improve methods and delivery of prevention services and to develop and refine interventions.

CDC provides leadership and assistance to domestic and international efforts to prevent, control and eliminate TB. CDC's national program provides grants to states and other entities for prevention and control services; researches the prevention and control of TB; funds demonstration projects; sponsors public information and education programs; and supports education, training, and clinical skills improvement activities to prevent, control, and eliminate TB.

Funding for HIV/AIDS, STD & TB Prevention for the last five years:

FY	FUNDING*
2001	\$1,044,070,000
2002	\$1,156,826,000
2003	\$1,146,648,000
2004	\$963,876,000
2005	\$960,711,000

*FY 2004 and FY 2005 funding levels reflect the removal of management and administrative costs under the new budget structure. FY 2001-2003 funding levels are not available in the new structure and include management and administrative costs.

PERFORMANCE ANALYSIS

HIV PREVENTION

CDC's overarching HIV Prevention goal comes from its strategic plan which states: "By 2010, reduce by 25 percent the number of new HIV infections in the U.S., as measured by a reduction in the number of HIV infections diagnosed each year among people less than 25 years of age, from 2,100 in 2000 to approximately 1,600 in 2010."

DOMESTIC HIV/AIDS

GOALS

- Decrease the number of persons at high risk for acquiring or transmitting HIV infection.
- By 2010, increase by 13% the proportion of HIV-infected people who know they are infected, as measured by the proportion diagnosed before progression to AIDS (baseline: 75% in 2000; 2010 target: 85%).
- By 2010, increase to at least 80% the proportion of HIV-infected people who are linked to appropriate prevention, care, and treatment services, as measured by those who report having received some form of medical care within three months of their HIV diagnosis.
- Strengthen the capacity nationwide to monitor the epidemic, develop and implement effective HIV prevention interventions and evaluate prevention programs.

Current Activities

- CDC's core set of HIV prevention activities includes surveillance research, intervention, capacity building, and evaluation. CDC and state and local health departments use surveillance to track the epidemic and understand its dynamics. Surveillance provides demographic, laboratory, clinical, and behavioral data that are used to identify populations at greatest risk for HIV infection. These data also help CDC estimate the size and scope of the epidemic.
- Surveillance – CDC provides funding and technical assistance to 65 state and local health departments to conduct HIV/AIDS case surveillance. Every state must report the number of persons diagnosed with AIDS each year. CDC has encouraged states to report HIV infections and has recently initiated projects in 33 areas to assess HIV incidence in conjunction with HIV case reporting. To better understand the dynamics of the epidemic, CDC also conducts specialized surveys of infected and high-risk persons.
- Intervention – Early in the epidemic, CDC recognized that the involvement of affected communities was a critical success factor in HIV/AIDS prevention programs. CDC uses several tools to involve communities in HIV prevention, including community planning, coordinated through health departments, and direct funding of CBOs. Through the HIV community planning process, communities tailor HIV prevention programs, supported by CDC funding to health departments, to local needs. Since 1989, CDC has provided funding directly to CBOs to conduct HIV prevention activities. Since 1999, CDC has received additional funding through the Minority AIDS Initiative to augment these existing efforts to address racial and ethnic disparities in HIV/AIDS. In 2004, CDC consolidated six of its programs for CBOs to a single program to implement outreach, counseling, testing, and prevention case management strategies as outlined in the Advancing HIV Prevention (AHP) initiative.
- Capacity-building – Underpinning intervention programs are capacity-building efforts. To build the capacity of its state and CBO partners to prevent HIV, CDC: (1) supports national meetings and satellite broadcasts as a forum for sharing new ideas and best practices; (2) funds nongovernmental organizations to provide training and materials; (3) provides direct technical assistance to CBOs; and (4) synthesizes and disseminates information on science-based interventions.
- Evaluation – CDC works to evaluate its programs so that the agency can monitor progress and refine its efforts. CDC is phasing in the new Program Evaluation and Monitoring System (PEMS). PEMS will be used to collect common data elements on HIV prevention activities to monitor progress on core performance indicators. Because it is standardized, PEMS will improve the quality of data reported, allow for more extensive querying and analysis of HIV data, and strengthen and improve the monitoring of HIV prevention programs.

Significant Accomplishments

- In 2003, CDC launched its new AHP initiative to increase the number of persons who are aware of their infection, link those persons with care and prevention services, and reduce new infections in the U.S. CDC supported a number of special demonstration projects as part of the initiative and incorporated the AHP strategies into its CBO, Capacity Building Assistance, and State HIV Prevention Programs. CDC estimates that implementation of the strategies of the initiative through CDC-funded programs and activities, including bulk purchases of rapid HIV test kits, will increase the number of HIV tests performed by 300,000 to 600,000 in 2004 and by 150,000 to 300,000 in 2005. This testing is estimated to increase the number of persons identified with HIV by 5,800 to 11,500 in 2004 and by 3,800 to 7,600 in 2005.
- CDC shipped more than 500,000 rapid test kits to health departments and community-based organizations in 35 states in 2003 and 2004. Training sessions were also offered to teach CBOs, health departments, and others how to conduct rapid HIV testing.
- CDC continued to publish HIV/AIDS surveillance data which is used across the Federal government and by other organizations to guide HIV-related programs, including those of CDC, HRSA, and HUD.
- The number of children nationwide reported to have acquired AIDS perinatally declined to 58 in 2003, down from 90 in 2002.

SEXUALLY TRANSMITTED DISEASES (STD) PREVENTION AND CONTROL

GOALS

On March 31, 2004, the CDC's STD program underwent a PART review by the Office of Management and Budget. This process helped CDC redirect and refine its performance measures for STD prevention and control.

The following goals will be measured through FY 2005:

- Reduce STD rates by providing chlamydia and gonorrhea screening, treatment, and partner treatment to 50 percent of women in publicly funded family planning and STD clinics nationally.
- Reduce the incidence of primary and secondary (P&S) syphilis.
- Reduce the incidence of congenital syphilis.

Beginning in FY 2006, CDC will measure the following goals:

- By 2010, reduce the incidence of Pelvic Inflammatory Disease (PID) by 15 percent (as measured by initial visits to physicians by women ages 15-44).
- Reduce the incidence of primary and secondary (P&S) syphilis by 12 percent and congenital syphilis by 62 percent.

Current Activities

- Infertility Prevention Program – CDC and the HHS Office of Population Affairs (OPA) are working with family planning, STD, and primary health care programs to implement infertility prevention activities for uninsured and underinsured women. CDC conducts research to identify the biological and behavioral determinant of chlamydia transmission, and assess the feasibility, acceptability, and cost-effectiveness of chlamydia screening for males. In 2003, CDC continued to support screening programs in all 65 STD project areas.
- Syphilis Elimination – CDC is increasing its focus on preventing syphilis transmission among men who have sex with men (MSM) because of recent resurgence of syphilis among this population. These increases represent a challenge in the control and eventual elimination of syphilis. CDC has supported the Eight Cities Project to develop and implement innovative strategies to stem the epidemic of syphilis among MSM in eight metropolitan areas in the U.S. CDC is also striving to maintain momentum in the success among populations originally targeted by syphilis elimination, i.e., minority heterosexuals.

As indicated in the table below, substantial progress has been made to date in these populations:

SYPHILIS	2003	2002	2001	2000	1999	1998	1997
Reported primary and secondary syphilis rate (per 100,000 population)	2.5	2.4	2.2	2.2	2.4	2.6	3.2
Syphilis-free counties	80.6%	80.7%	80.2%	80%	79%	78%	75%
Number of counties responsible for 50 percent of new cases	18	16	20	22	25	28	31
Black: white reported rate ratio	5:1	8:1	16:1	24:1	30:1	34:1	43:1

Significant Accomplishments

- Reduction in chlamydia prevalence in women in areas where large-scale screening programs are in place (Region X).
- Continued development of community-based support in the elimination of syphilis at demonstration sites resulting in an average 80% decline of P&S syphilis rates at these sites from 1999 to 2002.
- Conducted 36 comprehensive syphilis elimination program assessments in high syphilis morbidity areas.
- Continued enhancement of existing surveillance systems to include more and better quality data for disease monitoring purposes.
- Expanded the MSM Prevalence Monitoring Project from five cities in 1999 to ten cities in 2004, to monitor trends more closely in screening and prevalence of disease in this high-risk population.
- Developed and released a final report on the best available strategies for the prevention of HPV infection.

TUBERCULOSIS ELIMINATION

In 1989, CDC set a goal to eliminate TB in the U.S., with elimination defined as less than one case per 1,000,000 persons. This goal was reaffirmed in 1999 by the Advisory Council for the Elimination of Tuberculosis (ACET) and in 2000 by the Institute of Medicine (IOM).

Elimination of TB is a long-term goal that requires developing new tools and fully implementing the strategies recommended by the IOM. CDC developed the following interim goal for the nearer term:

GOAL

Progress towards TB elimination in the United States (defined as less than one case per 1,000,000 population) by achieving an interim TB rate of one case per 100,000 population in U.S.-born persons, 20 cases per 100,000 population in foreign-born persons residing in the United States, and three cases per 100,000 population overall, by 2010.

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

Current Activities

- Funding 68 cooperative agreements with state and local health departments for TB prevention and control (technical and financial assistance, laboratory support, model centers, and health care worker training).
- Working with 41 state and local advisory committees, representing patients and providers.
- Collaborating, through contracts and interagency agreements, with the Veterans Administration and other partners to maintain a consortium for clinical trials research.
- Supporting the Tuberculosis Epidemiologic Studies Consortium to strengthen TB epidemiological, behavioral, economic, laboratory, and operational research capacity within states, cities, and academic institutions.
- Working with a global partnership to implement the World Health Organization's "Stop TB" Initiative.
- Supporting a number of activities aimed at controlling TB along the U.S.-Mexico border. Most recently, CDC, in collaboration with international partners, piloted the Binational TB Card in three U.S. states and five Mexican states to ensure continuity of care and completion of TB treatment for patients who migrate between the U.S. and Mexico; to coordinate the referral of patients between the health systems of both countries; and to prevent multi-drug resistant strains of TB. If the pilot project proves successful, the U.S.-Mexico Binational TB Referral and Case Management Project will likely be expanded to other parts of the U.S. and Mexico.

Significant Accomplishments

- Since 1992, the most recent peak of the epidemic, reported cases of TB declined 44.2%. From 2002 to 2003, reported cases of TB in the U.S. declined 1.4% (from 15,075 to 14,871). This represents the eleventh consecutive year that TB cases have declined nationally.
- The case rate in 2003 was 5.1 per 100,000 populations, down from 5.7 in 2002.
- CDC published draft guidelines for the *Prevention of Transmission of Mycobacterium Tuberculosis in Healthcare Settings* to update current recommendations to address this important public health issue.

RATIONALE FOR THE BUDGET

The FY 2006 budget request of \$956,283,000 for HIV/AIDS, STD and TB Prevention represents a decrease of \$4,428,000 below the FY 2005 Enacted level of \$960,711,000. This includes the restoration of an FY 2005 Labor/HHS/Education reduction of \$475,000.

IT REDUCTION

Funding for the HIV/AIDS, STD and TB Prevention activity includes an information technology savings of \$4,903,000.

NARRATIVE JUSTIFICATIONS
INFECTIOUS DISEASES
HIV/AIDS, STD AND TB PREVENTION

OUTPUT TABLE

OUTPUT TABLE	FY 2004 ACTUAL	FY 2005 APPROPRIATION	FY 2006 ESTIMATE	FY 2006 +/- FY 2005
HIV Prevention				
Areas funded for HIV prevention	65	65	65	0
Areas funded for HIV/AIDS surveillance	65	65	65	0
No. of areas funded to estimate HIV incidence	34	34	34	0
No. of cities to conduct surveillance for behavioral risks for HIV infection in high-risk groups	24	24	24	0
No. of CBO projects funded to evaluate new testing strategies, including rapid testing [^]	12	0	0	0
No. of capacity building assistance providers supporting minority CBOs	30	27	27	0
Number of CBOs funded to support community level interventions*	166	166	166	0
Minority postdoctoral fellowships	4	4	4	0
STD Prevention				
Technical and financial assistance to grantees for STD Prevention	65	65	65	0
Syphilis Elimination Programs Funded	35	35	38	3
Regional infertility programs funded	10	10	10	0
STD/HIV Regional Prevention Training Centers funded	10	10	10	0
Percent of syphilis elimination funds awarded to project areas to support organizations serving affected populations	30	30	30	0
TB Elimination				
Number of cities, states, and territories provided financial and technical aid to conduct TB prevention and control activities and collect TB surveillance data	68	68	68	0
Number of research consortia funded	2	2	2	0
Number of studies funded under the TB Clinical Trials Consortia	3	3	3	0
Number of task orders funded under the TB Epidemiologic Studies Consortia	11	11	11	0
Number of communications disseminated via CD rom	10,500	11,000	11,500	500
Number of state public health laboratories participating in the TB Genotyping Network	50	50	50	0

[^] Plans for projects associated with the Advancing HIV Prevention Initiative are subject to change based on consultations with external collaborators, Congressional members, and other program stakeholders.

* Includes activities supported with HHS Minority AIDS funding

NARRATIVE JUSTIFICATIONS
 INFECTIOUS DISEASES
 HIV/AIDS, STD AND TB PREVENTION

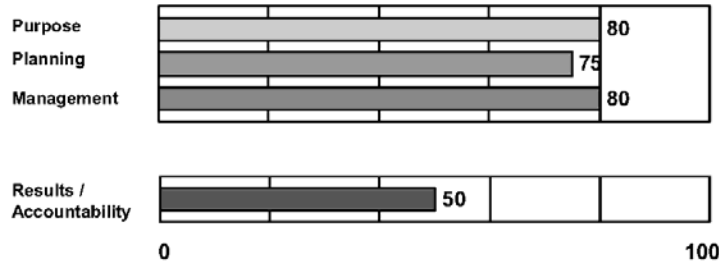
FUNCTIONAL TABLE

HIV/AIDS, STD, & TB Prevention Budget by Functional Activity (Dollars in Thousands)	FY 2004 Actual	FY 2005 Enacted	FY 2006 Estimate	FY 2006 +/- FY 2005
<u>HIV/AIDS, Research and Domestic</u>				
State & Local Health Departments	\$415,544	\$412,016	\$412,221	\$205
<i>Community Planning Grants (non-add)</i>	\$324,464	\$321,868	\$321,868	\$0
National/Regional/Other Organizations	\$179,424	\$177,901	\$173,086	(\$4,814)
CDC Research, Tech Asst & Prog. Supt	\$72,972	\$72,350	\$72,387	\$36
Subtotal, Research & Domestic -	\$667,940	\$662,267	\$657,694	(\$4,573)
Sexually Transmitted Diseases (STD)	\$158,580	\$159,633	\$159,709	\$76
Tuberculosis (TB)	\$137,356	\$138,811	\$138,881	\$69
Total -	\$963,876	\$960,711	\$956,283	(\$4,428)

Program: CDC: STD and TB

Agency: Department of Health and Human Services

Bureau: Centers for Disease Control and Prevention



Key Performance Measures from Latest PART

	Year	Target	Actual
Long-term Measure: The incidence of pelvic inflammatory disease as measured by initial visits to physicians by women ages 15 - 44	2000		254,000
	2001		244,000
	2002		197,000
	2010	168,000	
Long-term Measure: Incidence of syphilis, as measured by number of cases per 100,000.	2002		2.4
	2008	2.2	
Long-term Measure: Number of persons per 100,000 population with TB among US-born persons, foreign-born persons, and overall.	2000		3.5/24.1/5 .8
	2001		3.1/24.4/5 .6
	2002		2.9/23.1/5 .2
	2010	1.2/19.3/2 .9	

Rating: Adequate

Program Type: Competitive Grant

Program Summary:

The Sexually Transmitted Diseases (STD) and Tuberculosis (TB) activities at the Centers for Disease Control and Prevention (CDC) provide grants and technical assistance to State and local governments and organizations, conduct surveillance and support research. The STD activity at CDC works to control STDs, their transmission, and consequences. The TB activity at CDC works to promote health and quality of life by preventing, controlling, and eventually eliminating TB from the United States and helping to control TB worldwide by collaborating with other nations and partners.

The assessment found both the STD and TB activities have a clear purpose and address specific and ongoing problems. They have strong performance measures that focus on outcomes, but can make other improvements in planning and management. Details from the assessment include:

- The program has long-term and annual measures that can be used to track their impact on reducing the spread of disease and controlling their consequences.
- The program has not had regular evaluations or targeted evaluations to fill gaps in program performance.
- The program distributes its main grant awards to States based on historical distributions and does not target the majority of funds based on current need.
- The program could adopt more systematic ways of measuring and improving the efficiency of Federal operations, but has taken multiple steps to improve efficiency.

In response to these findings:

1. The program will track performance on the new long-term and annual performance measures this year and will also develop a measure to track its efficiency.
2. Over the next few years, the program will support evaluations of sufficient scope and quality to improve program performance.
3. The program will work to better target resources to directly address the program's purpose. The program will continue efforts to redistribute State funding for TB based on need, such as according to the number of reported cases and the case characteristics that complicate TB treatment. The program will also examine additional ways to better target State and local funding for STDs.

Program Funding Level (in millions of dollars)

<u>2004 Actual</u>	<u>2005 Estimate</u>	<u>2006 Estimate</u>
296	298	299

PART RECOMMENDATIONS

The STD/TB program was evaluated by PART during the FY 2006 budget cycle. Detailed information is provided below about the status of their PART recommendations.

RECOMMENDATION		COMPLETION DATE	ON TRACK? (Y/N)
Develop methods to target the program effectively so that resources directly address the program's purpose.		On-going	Y
COMMENT ON STATUS			
CDC awarded grants for the Comprehensive STD Prevention Systems (CSPS). Under these grants, recipients will report annually on performance measures. CDC is on track to award TB cooperative agreements for the new project cycle to state health departments. Awards will be made in Winter 2005.			
NEXT MILESTONE	NEXT MILESTONE DATE	LEAD ORGANIZATION	LEAD OFFICIAL
Award state health department cooperative agreements for new project cycle. Awards will utilize new funding formula based on TB disease burden.	1/31/05	CDC	Karen Long

RECOMMENDATION		COMPLETION DATE	ON TRACK? (Y/N)
Regularly conduct independent evaluations of sufficient scope and quality to support program improvements and evaluate effectiveness and relevance to the need.		On-going	Y
COMMENT ON STATUS			
The Office of the Inspector General (OIG) held its entrance conference with CDC's TB program on 12/15/2004 to examine TB control among undocumented immigrant detainees released into the community.			
NEXT MILESTONE	NEXT MILESTONE DATE	LEAD ORGANIZATION	LEAD OFFICIAL
Apply to OIG for inclusion of at least one STD program in evaluations scheduled for FY 2006.	2/28/05	CDC	Karen Long

NARRATIVE JUSTIFICATIONS
 INFECTIOUS DISEASES
 HIV/AIDS, STD AND TB PREVENTION

RECOMMENDATION		COMPLETION DATE	ON TRACK? (Y/N)
Hold Federal managers and program partners accountable for cost schedule and performance results.		On-going	Y
COMMENT ON STATUS			
CDC is working to revise Federal managers' (both Commissioned Corps and Civil Service) workplans to link employee performance with program performance.			
NEXT MILESTONE	NEXT MILESTONE DATE	LEAD ORGANIZATION	LEAD OFFICIAL
Work with the Commissioned Corps Office to determine if the goal section of the Commissioned Officer Effectiveness Report (COER) can be utilized to link the Officer's Performance Review to program performance. If this is possible, revise COERs as necessary. If it is not possible, work with the Commissioned Corps Office to develop new instrument.	2/28/05	CDC	Karen Long
Work with the Atlanta Human Resource Office to further modify performance plans for Civil Service employees in order to link employee performance plans with program performance.	2/28/05	CDC	Karen Long

IMMUNIZATION

AUTHORIZING LEGISLATION

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

Immunization (Dollars in Thousands)	FY 2004 Actual	FY 2005 Enacted	FY 2006 Estimate	FY 2006 +/- FY 2005
Discretionary Immunization	\$455,995	\$466,235	\$515,920	\$49,685
<i>Section 241, PHS Evaluation Transfer</i>	\$12,794	\$12,794	\$12,794	\$0
Proposed Law Changes¹	\$0	\$0	(\$100,000)	(\$100,000)
Subtotal, Discretionary Immunization Program (Proposed Law)	\$468,789	\$479,029	\$428,714	(\$50,315)
Vaccines for Children (VFC)- Current Law ²	\$1,052,030	\$1,634,850	\$1,502,333	(\$132,517)
Proposed Law Changes	\$0	\$0	\$140,000	\$140,000
Subtotal, VFC (Proposed Law)²	\$1,052,030	\$1,634,850	\$1,642,333	\$7,483
Total Immunization (Current Law)	\$1,520,819	\$2,113,879	\$2,031,047	(\$82,832)
Total Immunization (Proposed Law)	\$1,520,819	\$2,113,879	\$2,071,047	(\$42,832)

¹Proposed Law change reflects a \$100 million transfer of funds from the Section 317 discretionary account of the Public Health Service Act to the mandatory Vaccines for Children (VFC) program.

²Funding for VFC in FY 2004 reflects obligations. FY 2005 funding includes carryover of \$166 million from FY 2004.

STATEMENT OF THE BUDGET

The FY 2006 discretionary proposed law budget request of \$428,714,000 for Immunization represents a decrease of \$50,315,000 below the FY 2005 enacted level of \$479,029,000.

PROGRAM DESCRIPTION

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

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

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

In carrying out its mission, CDC:

- Awards grants through two programs administered by CDC: Section 317 of the Public Health Service Act and the Vaccines for Children (VFC) Program.
 - CDC provides grant support to assist state and local health departments in purchasing safe and effective vaccines and in planning, developing, and conducting childhood immunization programs.
 - The Section 317 program provides vaccines for children, adolescents and adults who primarily present at local health departments for immunization services but are not eligible for the VFC program. These populations are predominately underinsured (i.e., their insurance does not cover immunization), insured but they cannot afford high deductibles, or the working poor. Vaccines are provided to adolescents and adults, as funding allows, but to a much lesser extent than children.
 - The VFC program serves children without insurance, those eligible for Medicaid, American Indian/Alaska Native children, and children who are underinsured and receive care through Federally Qualified Health Clinics. Under the VFC program, federally purchased vaccines are distributed to public health clinics and enrolled private providers, enabling vaccination of all eligible children.
- Provides technical, epidemiological, educational, statistical and scientific assistance to state and local health departments.
- Strives to ensure a six month supply of recommended vaccines will be available for all U.S. children through a national pediatric stockpile.
- Strives for vaccine safety by monitoring harmful effects, conducting scientific research to evaluate the safety of vaccines, communicating the benefits and risks of vaccines to the public, and supporting the development of new vaccine administration devices, combination vaccines, and potential candidate vaccines to prevent additional infectious diseases.
- Conducts research and operational programs for the prevention and control of vaccine-preventable diseases.
- Supports a nationwide framework for effective surveillance of designated diseases for which effective immunizing agents are available.

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

COST-EFFECTIVENESS OF VACCINES*
For every \$1 spent:
DTaP saves \$27
MMR saves \$26
Perinatal Hepatitis B saves \$14.70
Varicella saves \$5.40
Inactivated Polio (IPV) saves \$5.45

*Source: NIP Data

Despite great success and achievements, there are challenges:

- Nearly one million two-year-olds in the United States have not received one or more of the recommended vaccines. Even though coverage levels for preschool immunization are high in many states, pockets of need, or areas within each state and major city where substantial numbers of under immunized children reside, continue to exist.
- Every day in the United States, approximately 11,000 babies are born who will need up to 22 vaccinations before they are two years old to be protected against 12 vaccine-preventable diseases. New vaccines, although greatly beneficial to public health, complicate an already complex immunization schedule and make it increasingly difficult to ensure complete immunization.
- The burden of vaccine-preventable diseases in adults in the United States is staggering. Approximately 43,000 U.S. adults die annually of vaccine-preventable diseases. Pneumonia and influenza were the fifth leading cause of death in all persons aged 65 and older based on 2000 national mortality data. One of the greatest challenges is extending the success in childhood immunization to the adult population.

- An early onset of outbreaks during the 2003-2004 influenza season led to increased demand for the vaccine, which exceeded supply. In addition, a supply shortage during the 2004-2005 flu season highlighted the need to provide incentive to manufacturers to produce sufficient flu vaccine. Future challenges include ensuring these children receive the influenza vaccine each fall, rather than in response to an outbreak.
- Immunizations are subject to a higher standard of safety than other medical interventions because they are given to healthy people. We need to maintain public confidence in immunizations, preserve high coverage levels, and prevent a resurgence of vaccine-preventable diseases.

Despite obstacles, CDC is committed to:

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

Funding for Immunization for the last five years:

FY	FUNDING*
2001	\$1,409,805,000
2002	\$1,616,774,000
2003	\$1,817,504,000
2004	\$1,520,819,000
2005	\$2,113,879,000

NOTE: Includes funding for the Vaccines for Children (VFC) program.

*FY 2004 and FY 2005 funding levels reflect the removal of management and administrative costs under the new budget structure. FY 2001-2003 funding levels are not available in the new structure and include management and administrative costs.

PERFORMANCE ANALYSIS

Immunization has been cited as one of the top ten public health achievements of the 20th century. Smallpox no longer exists. The threat of polio is close to being eradicated. In the U.S., vaccine-preventable diseases are at or near record low levels. Beginning in 1962, when the first national effort to improve the immunization status of children was proposed by Congress, CDC has counted immunization among its most vital programs, recognizing it as a core public health activity and perhaps the best example of effective primary prevention.

OVERALL GOAL: REDUCE THE NUMBER OF INDIGENOUS CASES OF VACCINE-PREVENTABLE DISEASES

All of CDC's immunization activities focus on eradicating or eliminating vaccine-preventable disease to the greatest possible extent. Only through integration of activities can the goals be achieved. Immunizing children by two years of age helps accomplish the goal of reducing the number of indigenous cases of vaccine-preventable disease. Within the last year, there were outbreaks of measles in the Republic of the Marshall Islands and China that resulted in cases in the United States.

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

INDIGENOUS CASES OF VACCINE PREVENTABLE DISEASES IN THE U.S. FINAL REPORTS FOR 2001, 2002, AND 2003					
	Highest # of Cases	2001	2002	2003	2010 Goal
Diphtheria	206,939	0	0	0	0
Measles	894,134	62	26	32	0
Mumps	152,209	266	253	222	0
Pertussis	265,269	3,163	4,109	3,719	2,000
Polio (paralytic, wild-type)	21,269	0	0	0	0
Rubella	57,686	14	10	7	0
Congenital Rubella Syndrome	20,000	3	1	1	0
Tetanus	1,733*	1	6	6	0

* Estimated

NATIONAL GOAL

GOALS

- Ensure that two-year olds are appropriately vaccinated.
- Increase the proportion of adults who are vaccinated annually against influenza and ever vaccinated against pneumococcal disease.

Current Activities:

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

- Section 317 grants provide vaccines for children, adolescents and adults who primarily present at public health departments for immunization services but are not eligible for the VFC program.
- VFC vaccine grants provide the financial security needed to make the national immunization system truly viable and permanent. First, the VFC program avoids the potential fluctuation of discretionary appropriations by ensuring funds for vaccines will be available. Second, the VFC program ensures that, as new pediatric vaccines are introduced and recommended, eligible children in all states will have equal access to these vaccines. Third, the VFC program allows CDC to purchase vaccines for those children at reduced federal contract prices. Finally, the VFC program makes federally purchased vaccines available through private physicians, increasing the number of sites where needy children can receive recommended vaccines on time, thus reducing missed opportunities and referrals to overburdened public clinics.

Awarding Grants to States for Operations/Infrastructure: Section 317 program Operations/Infrastructure grant activities include:

- Administering safe and effective vaccines, which remain the most cost-effective method of preventing human suffering and reducing economic costs resulting from vaccine-preventable diseases.

- Conducting AFIX (Assessing immunization coverage levels and practices in public and private provider settings, providing Feedback, encouraging Incentives for improved performance, and eXchange of information to stimulate competition between providers).
- Implementing new vaccine recommendations such as Influenza and Pneumococcal Conjugate Vaccine (PCV). Once implemented, PCV is projected to prevent more than one million episodes of childhood illness and approximately 120 deaths among children annually.
- Conducting activities scientifically proven to sustain and raise immunization coverage levels such as:
 - Identifying and improving coverage in "pockets of need" (areas within each state and major city where substantial numbers of under-immunized children reside), where the risks of vaccine-preventable disease outbreaks are increased. The development and use of state-based registries will help identify high-risk and under-immunized populations.
 - Using reminder and recall systems to improve immunization levels in children and adults (the development and use of state-based registries that include reminder/recall components provide critical information needed to improve and sustain coverage).
 - Linking immunization with the USDA Special Supplemental Nutrition Program for Women, Infants and Children (WIC), in which about 1.8 million infants (44 percent of the U.S. birth cohort) participate.

In recent years, immunization efforts have been expanded to include adolescents and adults, but to a much lesser extent than the support provided for childhood immunization activities. VFC operations activities include supporting activities to operate vaccine distribution systems, process vaccine orders from the states and from physicians in the private sector who participate in the VFC program, conduct provider recruitment and enrollment activities, conduct the AFIX strategy with VFC-enrolled private and public providers, and develop and implement vaccine accountability and evaluation plans.

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

- Collecting vaccination coverage data at the national, state, and local levels (with this information, the impact of national, state, and local policies and programs can be evaluated and monitored; the results provide an essential means of monitoring progress toward Year 2010 objectives).
- Conducting operational research to develop new and improved immunization delivery strategies in order to raise coverage levels.
- Continuing research to determine the occurrence and scientific basis for infrequent adverse events following vaccination.
- Maintaining a contractual mechanism for saving millions of dollars annually through the consolidated purchase of vaccine for states and local agencies.
- Conducting surveillance of vaccine preventable infectious diseases to detect and respond to outbreaks more rapidly.
- Assessing vaccination coverage levels in adults and conducting research to determine strategies for raising coverage levels.
- Increasing community participation, education, and partnerships through public information campaigns.
- Increasing education and training for providers and partnerships with community based and professional organizations, national minority organizations, and other Federal agencies.

Purchasing vaccines for the stockpile program:

- Pediatric Stockpile: CDC has authority through the VFC program to purchase a six month national supply of pediatric vaccines for the stockpile. CDC has purchased six-month stockpiles of MMR, varicella and IPV vaccines. CDC has purchased partial stockpiles of hepatitis b, hepatitis a, PCV and Hib vaccines.
- Influenza Stockpile: Demand for the influenza vaccine during the 2003-2004 influenza season significantly exceeded supply. Unfortunately, the current manufacturing process does not allow for additional vaccine to be produced in a timely fashion once supplies are low. These factors have illustrated the need for a plan to ensure the availability of influenza vaccine in the U.S. CDC has legislative authority through the VFC program to purchase influenza vaccine for a national stockpile program for children through 18 years of age. In FY 2004, CDC has purchased influenza vaccine for a national stockpile which will serve as a safety net

for the U.S. In the event that influenza vaccine demand exceeds supply, CDC will authorize use of the stockpiled influenza vaccine in public and private provider settings: manufacturers will be able to “borrow against” the stockpile, and stockpiled vaccine may be made available directly to state immunization programs through the VFC program. If demand does not exceed supply and there is vaccine remaining in the stockpile, vaccine will be disposed of on June 30, 2005 because it expires and can not be used for the next influenza season. Funding is included in the FY 2005 and 2006 VFC budgets to purchase influenza vaccine for the stockpile for the 2005-2006 and 2006-2007 influenza seasons.

Significant Accomplishments

- The nation’s childhood immunization coverage rates are at record high levels for every vaccine and for all the vaccination series measures. As childhood immunization coverage rates increase, cases of vaccine preventable diseases decline significantly. For example, during the 1990s, approximately 11,000 hospitalizations and 100 deaths occurred each year due to varicella. CDC has made great progress in educating health care providers and the public about the benefits of varicella vaccine. Coverage for varicella vaccine reached 85 percent in 2003 as opposed to only 43 percent in 1998. As a result, annual deaths have decreased to 2 in 2003.

VACCINATION COVERAGE LEVELS AMONG CHILDREN AGED 19 - 35 MONTHS, NATIONAL IMMUNIZATION SURVEY, U.S								
Vaccine/ Dose	1997 (%)	1998 (%)	1999 (%)	2000 (%)	2001 (%)	2002 (%)	2003 (%)	2010 Goal
DTP 3+	96	96	96	94	94	95	96	90
Polio 3+	91	91	90	90	89	90	92	90
Hib 3+	93	93	94	93	93	93	94	90
MMR 1+	91	92	92	91	91	92	93	90
Hepatitis B 3	84	87	88	90	89	90	92	90
Varicella	26	43	58	68	76	81	85	90

- In October, 2004, CDC was notified by Chiron Corporation that none of its influenza vaccine would be available for distribution in the U.S. for the 2004-2005 influenza season. This action reduced by approximately one half the supply of influenza vaccine that was expected to be available this season. CDC, in collaboration with immunization programs nationwide, allocated available influenza vaccine to state health departments, which helped ensure the doses reached those people at highest risk for complications from influenza. CDC worked closely with Aventis Pasteur and the vaccine distributors to design a vaccine ordering and distribution system through CDC’s Secure Data Network. The Network allowed immunization programs to view vaccine doses already shipped and the distribution of priority populations by county in order to best direct vaccine as needed to public and private providers and health care facilities.
- CDC’s consolidated vaccine purchase contracts provide access to vaccines for state and local health departments at substantially reduced prices and have saved over \$900 million in 2003 when compared to what would have been paid at private sector vaccine prices.
- The VFC program enables children to receive immunizations at their physicians’ offices where they receive regular care instead of being referred to the local health department. One study (*Fairbrother and Colleagues*) showed that VFC caused vaccination rates to increase by 23 percent in inner city New York.
- Vaccine stockpiles can be used to interrupt disease outbreak situations and ameliorate short lived production problems. In 2003, CDC began purchasing vaccines to expand the national stockpile program to include a six month supply for all routinely recommended childhood vaccines. CDC has purchased six-month stockpiles of measles, mumps, rubella (MMR), varicella, and inactivated polio (IPV) vaccines. CDC has also purchased partial stockpiles of hepatitis B, hepatitis A, PCV and Haemophilus influenzae type b (Hib) vaccines. CDC plans to continue purchasing those vaccines and others, like diphtheria, tetanus and pertussis (DTaP), for the stockpiles.

VACCINE SAFETY

GOAL: IMPROVE VACCINE SAFETY SURVEILLANCE.

Current Activities

Using a multi-faceted approach to identify possible vaccine side effects, CDC:

- Manages the Vaccine Adverse Event Reporting System (VAERS), in collaboration with the Food and Drug Administration, which serves as an early warning system to detect problems that may be related to vaccines.
- Supports the Vaccine Safety Datalink (VSD) project, a large linked database containing comprehensive medical and immunization histories of over 7.5 million people to enable vaccine safety research studies comparing incidence of health problems between vaccinated and unvaccinated people.
- Implemented the Clinical Immunization Safety Assessment (CISA) Network to provide in depth, standardized clinical evaluations for individuals with unusual or severe vaccine adverse events.

Significant Accomplishments

- CDC plays a vital role in striving for vaccine safety by monitoring harmful effects, conducting scientific research to evaluate the safety of vaccines, communicating to the public the benefits and risks of vaccines, and supporting development of new vaccine administration devices, combination vaccines, and potential candidate vaccines to prevent additional infectious diseases. Assessments of the risks and benefits of vaccines influence vaccine policy and recommendations.

RATIONALE FOR THE BUDGET

DISCRETIONARY IMMUNIZATION

The FY 2006 discretionary proposed law budget request of \$428,714,000 for Immunization represents a decrease of \$50,315,000 below the FY 2005 Enacted level of \$479,029,000. The request reflects a proposed law transfer of \$100,000,000 from the discretionary 317 program to the mandatory VFC program and an increase of \$50,000,000 to support two initiatives, as described below.

INFLUENZA VACCINE PURCHASE: (+\$50,000,000)

Maintaining an abundant influenza vaccine supply is critically important for protecting the public's health and improving our preparedness for an influenza pandemic. Based on the influenza vaccine shortage in the 2004-2005 influenza season, it is essential to add stability and strength to the U.S. influenza vaccine market. CDC's FY 2006 budget request includes two initiatives for influenza vaccine purchase to help create a more stable vaccine market and ensure a plentiful supply of vaccine.

Back-end Sales Guarantee (+\$30,000,000): A supply shortage during the 2004-2005 flu season highlighted the need to provide incentive to manufacturers to produce sufficient flu vaccine. In response, CDC plans to enter into back-end sales guarantee contracts beginning in FY 2005 and continuing in FY 2006. The increase of \$30 million will allow CDC to offer an incentive to manufacturers to increase vaccine production for upcoming influenza seasons by ensuring the purchase of unused vaccines at the end of the influenza season.

Influenza Vaccine Purchase (+20,000,000): The increased funding of \$20 million for vaccine purchase will allow CDC to direct funding through the Section 317 program to influenza vaccine purchase in FY 2006. CDC will request an increase in the routine influenza vaccine supply contracts consistent with the additional \$20 million in funding being made available. This vaccine will be allocated to states based on need and supply.

IT REDUCTION

Funding for the Immunization activity includes an information technology savings of \$315,000.

Current Law:

The FY 2006 discretionary immunization current law estimate of \$528,714,000 does not reflect the proposed law change but does reflect the increase of \$50,000,000 for influenza activities.

Proposed Law:

The FY 2006 discretionary immunization proposed law estimate of \$428,714,000 reflects the proposed law change and the increase of \$50,000,000 for influenza activities.

VACCINE PURCHASE GRANTS: (-\$100,000,000)

Currently, underinsured children can receive vaccines purchased with VFC program funds only at Community Health Centers and Federally Qualified Health Centers. The change to VFC legislation proposed allowing these children to receive VFC vaccine at a state or local public health clinic. Amending the VFC authorizing legislation to expand access points for these children could decrease the amount of discretionary vaccine purchase appropriations needed by \$100 million. Also, the proposed legislation would ensure these children have rapid access to new vaccines such as PCV. The estimate of \$100 million is based on studies conducted in two states. CDC will conduct additional studies on cost implications based on the proposed change.

This reduction in the amount of discretionary funding needed would be contingent upon passage of the proposed amendment to the VFC legislation.

VFC PROGRAM

In FY 2006, CDC requests a total proposed law funding level of \$1,642,333,000 for the VFC program. The request represents an increase of \$7,483,000 over the FY 2005 level of \$1,634,850,000.

In FY 2005, two new vaccines became available for purchase through the VFC program and excise tax has been added to two existing vaccines. These changes have increased the vaccine purchase budget in FY 2005 and FY 2006.

Tetanus-Diphtheria Vaccine - Since 1998, the tetanus and diphtheria vaccines (Td and DT) had not been available for purchase through the VFC program due to a price cap established in the VFC authorizing legislation for all vaccines for which a CDC contract existed prior to May 1, 1993. The authorizing legislation established a price cap for these vaccines that was so low the manufacturers concluded that it was not economically feasible to sell to the government. Aventis Pasteur, Inc. has developed a new preservative-free Td vaccine product (brand name DECAVAC). This vaccine will not be subject to the VFC price cap since the formulation has changed since 1993. On December 1, 2004, CDC added the vaccine to the federal consolidated vaccine purchase contract. In addition, this change will enable CDC to procure for its national stockpile. An estimated two million doses are needed for the stockpile – one million to be purchased in FY 2005 and one million to be purchased in FY 2006.

Live Attenuated Influenza Vaccine (LAIV) Flu Mist - In October 2004, ACIP approved the VFC resolution incorporating the use of LAIV. Eligible groups for LAIV include healthy children and adolescents aged 5 – 18 years who are household contacts or out-of-home caregivers of persons in the following high-risk groups (provided that the contacts are not severely immunocompromised); children less than two years old; adults aged 50 years or older; persons with chronic disorders of the pulmonary or cardiovascular systems including asthma; persons who have required regular medical follow-up or hospitalization during the preceding year for chronic metabolic diseases, renal dysfunction, hemoglobinopathies, or immunosuppression; children and adolescents aged 2 – 18 years who are receiving long-term aspirin therapy and may be at risk for developing Reye syndrome after influenza; residents of nursing homes and other chronic-care facilities that house persons at any age who have chronic conditions; and women who will be pregnant during influenza season.

Excise Tax for Hepatitis A and Influenza Vaccines – In October 2004, the President signed a bill which included \$0.75 vaccine excise tax provisions covering hepatitis A and trivalent influenza vaccines.

Current Law:

The FY 2006 current law estimate for VFC is \$1,502,333,000. This reflects a decrease of \$132,517,000 below the FY 2005 level of \$1,634,850,000. The majority of the decrease is due to less funding being needed in FY 2006 for the purchase of vaccines for CDC's stockpile than in FY 2005, based on manufacturers' projections of when they can produce vaccines needed for the stockpile.

Proposed Law:

The FY 2006 proposed law estimate of \$1,642,333,000 represents an increase of \$140,000,000 over the current law request.

VFC VACCINE PURCHASE (+\$140,000,000)

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

OUTPUT TABLE

OUTPUT TABLE	FY 2004 ACTUAL	FY 2005 APPROPRIATION	FY 2006 ESTIMATE	FY 2006 +/- FY 2005
317 Vaccine Purchase Grants				
# of PCV doses purchased ¹	.90M	.90 M ²	.87M	(.03M)
# of routine influenza doses purchased ¹	.90M	.90M	2.9M ³	2.0M
State Operations/Infrastructure Grants				
Number of states with 90 percent or greater coverage for 3+ Hib	50	50	50	0
Number of states with 90 percent or greater coverage for 1+ MMR	50	50	50	0
Prevention Activities				
Support clinical evaluations to study newly hypothesized or alleged vaccine related syndromes	80	80	80	0
Registries participating in safety monitoring with VAERS	17	17	17	0
Case reports submitted by immunization registries	275	275	275	0
CISA centers in operation	7	7	7	0
VFC Vaccine				
Number of PCV doses purchased ¹	6.2M	8.3M	8.7M	.4M
Number of influenza vaccine doses purchased for routine administration ¹	4.5M	6.3 M	6.3M	0

¹ Based on Current Law

² Estimated purchase; the FY 2005 appropriation includes an increase for vaccine purchase, however due to the anticipated price increase of vaccines in 2005 the number of PCV doses purchased may not increase.

³ Estimate based on an additional \$20 million provided in the FY 2006 budget request specifically for influenza vaccine purchase. Pricing and number of doses will not be known until contract proposals are submitted.

FUNCTIONAL TABLE

Immunization Budget by Functional Activity (Dollars in Thousands)	FY 2004 Actual	FY 2005 Enacted	FY 2006 Estimate	FY 2006 +/- FY 2005
<u>317 Immunization Program</u>				
Vaccine Purchase Grants (Current Law)	\$209,998	\$215,680	\$265,680	\$50,000
Vaccine Purchase Grants (Proposed)	\$209,998	\$215,680	\$165,680	(\$50,000)
State Operations/Infrastructure Grants	\$195,798	\$195,798	\$195,798	\$0
Subtotal, 317 Immunization Program (Current Law) -	\$405,796	\$411,478	\$461,478	\$50,000
Subtotal, 317 Immunization Program (Proposed Law) -	\$405,796	\$411,478	\$361,478	(\$50,000)
<u>Program Operations</u>				
Vaccine Tracking (SPARX)	\$0	\$4,960	\$4,960	\$0
Prevention Activities	\$62,993	\$62,591	\$62,276	(\$315)
Subtotal, Program Operations -	\$62,993	\$67,551	\$67,236	(\$315)
Total (Current Law) -	\$468,789	\$479,029	\$528,714	\$49,685
Total (Proposed Law) -	\$468,789	\$479,029	\$428,714	(\$50,315)

HEALTH PROMOTION

Health Promotion (Dollars in Thousands)	FY 2004 Actual	FY 2005 Enacted	FY 2006 Estimate	FY 2006 +/- FY 2005
BA	\$932,067	\$1,024,033	\$964,421	(\$59,612)
FTE	831	804	821	17

INTRODUCTION

The Health Promotion budget activity reflects CDC's work to enhance the potential for full, satisfying and productive living across the lifespan for all people in all communities. This is accomplished by promoting improved public health through increased efficiencies, fostering strong collaborations, and integrating synergistic programs and messages. Health Promotion is home to Genomics and Disease Prevention, Chronic Disease Prevention and Health Promotion, and Birth Defects and Developmental Disabilities activities.

The three components that comprise Health Promotion support the overarching mission to enhance the health and quality of life of all people. These components function as a natural organizational unit because of their interrelatedness in health issues. The genomics component has a history of contributions to birth defects prevention, and CDC continues to find additional opportunities in this area. Increasingly, the future utility of genomics lies in the work on cancer genetics and family history to enable targeted interventions for chronic diseases. In addition, the Chronic Disease and Health Promotion and Birth Defects and Developmental Disabilities components work closely on a number of issues, ranging from premature births to preventing complications of disabling conditions caused by chronic conditions.

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

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

- A preconception care - consumer promotion, education and outreach initiative to help women protect their health and the lives of their children.
- A broad-based consumer education initiative around healthy living and living longer, better quality lives. The initiative would address the links between family history and major risk factors, such as nutrition, physical activity, tobacco use, and preventive screenings, as the underlying causes of the leading causes of death and disability.

CHRONIC DISEASE PREVENTION, HEALTH PROMOTION, AND GENOMICS

AUTHORIZING LEGISLATION

General Authority: PHSA §§ 301, 307, 310, 311, 317, 317K, 327, 340D, 352, 391, 1102, 1501-1510, 1706; Public Health Cigarette Smoking Act of 1969; Comprehensive Smoking Education Act of 1984; Comprehensive Smokeless Tobacco Health Education Act of 1986; Fertility Clinic Success Rate and Certification Act of 1992; Prostate cancer: PHSA § 317D; Cancer registries: PHSA §§ 399B-399D, 399F2; Diabetes Among Children and Youth: PHSA § 317H; Safe Motherhood/Infant Health Promotion: PHSA §§ 317K(a), 317K(b), 317L; Childhood Obesity Prevention PHSA §§ 399W-399Z; Oral Health Promotion: PHSA § 317M; Prevention centers: PHSA §§ 301, 310, 311, 3173, 391, 1102, 1706; Supplemental Grants for Preventive Health Services (WISEWOMAN): 1509; Hematological Cancer Research Investment and Education: 419C; Breast and cervical cancer prevention: PHSA §§ 301, 340D, 1501-1510; Breast and Cervical Cancer Mortality Prevention Act.

Chronic Disease Prevention, Health Promotion, and Genomics (Dollars in Thousands)	FY 2004 Actual	FY 2005 Enacted	FY 2006 Estimate	FY 2006 +/- FY 2005
BA	\$818,171	\$899,457	\$840,858	(\$58,599)

STATEMENT OF THE BUDGET

The FY 2006 budget request of \$840,858,000 for Chronic Disease Prevention, Health Promotion and Genomics represents a decrease of \$58,599,000 below the FY 2005 Enacted level of \$899,457,000.

PROGRAM DESCRIPTION

More than 1.7 million Americans die of a chronic disease each year, accounting for about 70 percent of all deaths in the United States. In addition, the prolonged course of illness and disability from diseases such as arthritis, cancer, diabetes, heart disease, and stroke results in pain and suffering, poor quality of life, and disability for millions of Americans. Cardiovascular disease (including heart disease and stroke) alone is the leading cause of death in the U.S., affecting over 60 million Americans and costing the nation more than \$351 billion in direct and indirect health care costs per year. Medical care for people with chronic diseases accounts for more than 75 percent of the \$1.4 trillion spent as a nation on medical care. Furthermore, if disease patterns stay the same, by the year 2030 the healthcare system will have to spend an additional \$300 to \$400 billion per year, excluding inflation, to treat the chronic diseases of an aging population. This expense means increased costs of \$1,500 per year for every person in the United States just to help support the care of our older citizens.

Chronic diseases are caused by behaviors that are preventable; for example, tobacco use is the single most preventable cause of death and disease, with poor diet and sedentary behavior close behind and on the rise. CDC works to prevent the occurrence and progression of chronic diseases by reducing or eliminating behavioral risk factors, by increasing the prevalence of health promotion practices, and by detecting and managing chronic disease early to avoid complications. Today's most serious and expensive health and social problems are caused, in large part, by behaviors established during youth – tobacco use, diets high in fat and sugar, inadequate physical activity, drug and alcohol use, and risky sexual behaviors. These behaviors place young people at significantly increased risk for severe health problems, both now and in the future.

CDC's strategy for preventing the leading causes of death in the United States is a crosscutting approach: support for state and community programs, surveillance, prevention research, evaluation, and health promotion.

CDC plays a leadership role in coordinating and catalyzing the efforts of numerous public and private partners such as other government agencies, professional organizations, voluntary organizations, academic institutions, community organizations, private organizations, and businesses. The expertise, experience, and outreach capabilities of these partners substantially extend CDC's effectiveness in reaching people at highest risk for chronic diseases.

A significant portion of the CDC's mission involves supporting and managing public health programs implemented by states and localities, which prevent and control chronic diseases. To support these programs, CDC provides technical consultation in planning, establishing, maintaining, and evaluating prevention and control strategies for selected chronic disease and health promotion activities. CDC project officers are the primary conduit through which this consultation is provided and/or coordinated.

Funding for Chronic Disease Prevention & Health Promotion for the last five years:

FY	FUNDING*
2001	\$749,708,000
2002	\$746,731,000
2003	\$789,972,000
2004	\$818,171,000
2005	\$899,457,000

*FY 2004 and FY 2005 funding levels reflect the removal of management and administrative costs under the new budget structure. FY 2001-2003 funding levels are not available in the new structure and include management and administrative costs.

PERFORMANCE ANALYSIS

A. HEART DISEASE AND STROKE

Heart disease and stroke, principal components of cardiovascular disease (CVD), are our nation's first and third leading causes of death for both men and women and account for almost 40 percent of all deaths. Nearly 930,000 Americans die of heart disease and stroke each year – one person every 34 seconds. About 70 million Americans live with one or more cardiovascular conditions. CVD claims more lives each year than the next five leading causes of death combined. Major disparities in disease risk adversely affect people with low income or little education, older adults, and African-Americans.

Much of the national burden could be prevented, but effective preventive measures are currently underused. For example, a modest 12-13 percent reduction in blood pressure can reduce heart attack by 21 percent, stroke by 37 percent and overall CVD mortality by 25 percent. Quick and appropriate emergency care for stroke victims can, in many cases, prevent permanent disability from stroke.

GOAL: REDUCE DEATH AND DISABILITY DUE TO HEART DISEASE AND STROKE AND ELIMINATE DISPARITIES.

Current Activities

- CDC and states are working to: (1) prevent and control high blood pressure and high blood cholesterol, major risk factors for heart disease and stroke; (2) improve quality of care to prevent and manage high blood pressure, stroke, and heart disease; (3) improve access to appropriate and often life-saving emergency care quickly, by educating the public about the signs and symptoms of heart attack and stroke and improving emergency care services, such as 911 coverage and emergency stroke therapy; and, (4) eliminate health disparities.
- In FY 2005, CDC will fund 33 state heart disease and stroke prevention programs. Eighteen states and the District of Columbia will receive grants for planning and capacity-building, which prepares them for program implementation.
- Funding received in FY 2005 will allow 2 states to go from capacity-building to basic implementation of heart disease and stroke prevention programs. Fourteen states will receive grants for basic program implementation. CDC also continues to support specific state- and local-based research projects addressing CVD among racial and ethnic populations.
- CDC's nationwide heart disease and stroke prevention program will place an additional focus on stroke treatment and prevention, which includes preventing the major risk factor for stroke – uncontrolled high blood pressure. Because there is little state and national data to monitor improvements in heart disease, stroke, high blood pressure, and high cholesterol, CDC will develop registries and new surveillance systems to increase the surveillance capacity of state programs. In FY 2004, CDC implemented the Paul Coverdell National Acute Stroke Registry, funding four state-based registries to reduce death and disability associated with stroke and to improve the quality of care and life among stroke survivors.

Significant Accomplishments

- Wisconsin's Cardiovascular Health Program is improving control of high blood pressure through partnerships with health plans. Among participating health plans, the percentage of patients who had high blood pressure controlled increased by nearly 30% from 2000 to 2003.
- CDC published a Communications Guide for educating key constituencies about how to make changes in communities, health care settings, work sites, and schools to promote cardiovascular health and how to increase public awareness of signs and symptoms of a heart attack and stroke.
- CDC, in partnership with the World Health Organization, published The Atlas of Heart Disease and Stroke, a world atlas. The atlas globally maps the types of cardiovascular diseases, the burden and risk factors, actions to be taken and the future outlook of CVD.

B. CANCER PREVENTION AND CONTROL

Cancer is the second leading cause of death in the U.S. Since 1990, 17 million new cancer cases have been diagnosed, more than 1.3 million new cases in 2003 alone. According to the National Institutes of Health, in 2004 the direct and indirect costs of cancer in the U.S. totaled \$189 billion. Screening tests for breast, cervical, and colorectal cancer reduce the number of deaths from these diseases, and screening tests for cervical and colorectal cancer can actually prevent the development of cancer through the early detection and treatment of precancerous conditions. Skin cancer is largely preventable when sun protection measures are consistently used.

1. COMPREHENSIVE CANCER CONTROL (CCC)

Comprehensive cancer control is based on the following four principles: (1) states use data and research to identify priorities; (2) the full scope of cancer care is addressed, ranging from primary prevention to early detection and treatment, to survivorship and end-of-life issues; (3) all state cancer-related programs are coordinated, which integrates programs and fosters leadership; and, (4) states integrate expertise and efforts from many disciplines, basic and applied research, evaluation, health education, program development, public policy, surveillance, clinical services, and health communications.

GOALS (HEALTHY PEOPLE 2010)

- Reduce the overall cancer death rate.
- Increase the proportion of cancer survivors who are living five years or longer after diagnosis.

Current Activities and Significant Accomplishments

In FY 2005, CDC is supporting 61 comprehensive cancer control programs across the U.S., including five tribes and tribal organizations and six territories. With this support, public health agencies work to establish broad-based CCC coalitions, assess the burden of cancer, determine priorities for cancer prevention and control, and develop and implement CCC plans.

2. EARLY DETECTION OF BREAST AND CERVICAL CANCER

Other than skin cancer, breast cancer is the most commonly diagnosed cancer and the second leading cause of cancer death among women in the U.S. Timely mammography screening could prevent approximately 16 percent of all deaths from breast cancer among women over age 40. Regular pap smear testing can actually prevent cervical cancer, as well as find it early when it is most curable.

GOALS

- Increase early detection of breast and cervical cancer, especially among high-risk, underserved women.
- Expand community-based breast and cervical cancer screening and diagnostic services to low-income, medically underserved women; for women diagnosed with cancer or pre-cancer, ensure access to treatment.

Current Activities

CDC's National Breast and Cervical Cancer Early Detection Program (NBCCEDP) provides funding to all 50 states, four territories, the District of Columbia, and 13 American Indian/Alaska Native tribal organizations to conduct breast and cervical cancer screening and diagnostic programs. CDC works with these grantees to ensure that women diagnosed through NBCCEDP have access to treatment. In addition, the Breast and Cervical Cancer Prevention and Treatment Act of 2000 gave states the option to choose to provide treatment through Medicaid. To date, 49 states

and the District of Columbia have received approval for the program. For FY 2004 and FY 2005, several new activities have been identified as priorities for CDC. These include advancing the use of geographic information technologies (GIS) and implementing evidence-based case management and recruitment interventions. CDC is also refining the program's strategic and evaluation plans.

Significant Accomplishments

- Helped to increase mammography use by women aged 50 years and older by 20 percent since the program's inception in 1991. NBCCEDP targets low-income women with little or no health insurance and has helped reduce disparities in screening for women from racial and ethnic minorities. Approximately 50 percent of screenings provided by the program were to women from racial or ethnic minority groups.
- Provided 4.6 million screening tests to nearly 1.9 million women. The program has diagnosed nearly 17,000 breast cancers, 61,500 precancerous cervical lesions, and over 1,157 cases of invasive cervical cancer.

3. NATIONAL PROGRAM OF CANCER REGISTRIES

The National Program of Cancer Registries collects data on the occurrence of cancer; the type, extent, and location of the cancer; and the type of treatment.

GOAL: ENHANCE NATIONAL AND WORLDWIDE CANCER SURVEILLANCE; IMPROVE ACCESSIBILITY AND USE OF POPULATION-BASED, CANCER SURVEILLANCE DATA; AND DEVELOP AND DISSEMINATE STANDARDS FOR CANCER DATA COMPLETENESS, TIMELINESS, AND QUALITY.

Current Activities

CDC's National Program of Cancer Registries is a component of CDC's state-based cancer control strategy. CDC funds 45 states, three territories, and the District of Columbia for cancer registries. State cancer registry data are essential for directing and evaluating cancer prevention and control program activities. For example, cancer registry information can be used to target specific populations for breast, colorectal, and cervical cancer screening. Two CDC-supported state programs, the Illinois Breast and Cervical Cancer program and the Illinois Cancer Registry, collaborated to increase the percentage of women diagnosed at the earliest stages of breast cancer. In counties that participated in the program for at least five years, the percentage of breast cancer cases diagnosed at the in situ stage increased 110 percent. Counties not participating in the program did not experience such an increase.

In FY 2005, CDC is increasing funds to registry programs to promote the use of cancer data in the development and evaluation of interventions. Funding will help states collect, report, and respond to disparities in cancer burden by race and ethnicity and by geographic area. CDC has expanded research projects to collect additional data to evaluate quality of cancer care and clinical practice patterns in specific populations, including racial and ethnic minorities. CDC has also supported operational research projects to enhance data collection, quality, timeliness, and management of cancer registries.

Significant Accomplishments

Released in November 2004, the *U.S. Cancer Statistics: 2001 Incidence Report* marks the third time that CDC and NCI, in collaboration with the North American Association of Central Cancer Registries, have combined their cancer incidence data sources to produce a new set of official federal statistics on cancer incidence. The report provides state-specific and regional data for cancer cases diagnosed in 2000, the most recent year for which data are available. Cancer statistics from 43 states, six metropolitan areas and the District of Columbia are included in the report. This represents 92 percent of the U.S. population and will contribute to the national understanding of cancer risks and help promote efforts for science-based cancer prevention and control programs. This report is released annually.

4. COLORECTAL CANCER

Colorectal cancer is the second leading cause of cancer-related death in the U.S., despite the availability of screening tests and the efficacy of precancerous polyp removal. Findings from CDC's Behavioral Risk Factor Surveillance System (BRFSS) indicate that in 2002, only 48 percent of men and 48 percent of women aged 50 or older had ever been screened for colorectal cancer.

GOALS (HEALTHY PEOPLE 2010)

- Reduce the colorectal cancer death rate.
- Increase the proportion of adults who receive a colorectal cancer screening examination:

- Adults aged 50 years and older who have received a fecal occult blood test (FOBT) within the preceding two years.
- Adults aged 50 years and older who have ever received a sigmoidoscopy.

Current Activities and Significant Accomplishments

CDC continues to support collaborative strategies to promote colorectal cancer screening by educating health care providers and the public about the benefits of screening, the availability of effective screening procedures and current screening guidelines, and by providing funding to state programs to address colorectal cancer priorities. In collaboration with the Centers for Medicare and Medicaid Services (CMS), CDC created and implemented Screen for Life – the National Colorectal Cancer Action Campaign. This campaign educates Americans aged 50 years or older about the importance of screening for colorectal cancer and informs them about Medicare’s colorectal cancer screening benefit.

5. PROSTATE CANCER

Prostate cancer is the most commonly diagnosed cancer among American men and is second only to lung cancer as the primary cause of cancer-related deaths for men in the U.S. The American Cancer Society estimates that 230,110 new cases of prostate cancer were diagnosed and that approximately 28,320 men will die of the disease in 2004. African-American men of every age are typically diagnosed with more advanced states of prostate cancer than are white men.

GOAL (HEALTHY PEOPLE 2010): REDUCE THE PROSTATE CANCER DEATH RATE.

Current Activities and Significant Accomplishments

CDC is working with partners to better understand prostate cancer, with particular emphasis on the African-American community, and the high rate of death among African-American men. CDC is enhancing prostate cancer data in state cancer registries, especially with regard to stage of diagnosis, quality of care, and racial and ethnic information. In FY 2002, CDC prepared Prostate Cancer Screening: A Decision Guide for men who are considering a first-time prostate cancer screening test or who want more information on regular screening. In FY 2003, CDC prepared a similar guide for African-American men along with a web-based slide presentation called Screening for Prostate Cancer: Sharing the Decision, to help physicians explain prostate cancer and screening to patients more effectively.

6. SKIN CANCER

Skin cancer is the most common form of cancer in the U.S. The American Cancer Society estimates that during 2004, about one million new cases of basal cell or squamous cell carcinoma and about 55,100 new cases of malignant melanoma are expected to be diagnosed.

GOALS (HEALTHY PEOPLE 2010)

- Reduce the rate of melanoma cancer deaths.
- Increase the proportion of persons who use at least one of the following protective measures that may reduce the risk of skin cancer: avoid the sun between 10 a.m. and 4 p.m., wear sun-protective clothing when exposed to sunlight, use sunscreen with a sun-protective factor (SPF) of 15 or higher, and avoid artificial sources of ultraviolet light.
- Increase the proportion of adolescents in grades nine through 12 who follow protective measures that may reduce the risk of skin cancer.

Current Activities and Significant Accomplishments

To disseminate information about the importance of minimizing ultraviolet exposure during childhood, CDC published Guidelines for School Programs to Prevent Skin Cancer in 2002. The Guidelines will help state and local education agencies and schools play a role in reducing unsafe sun exposure.

Also, CDC is developing communication tools for adaptation by education partners to increase awareness, formulate policy, and enhance the school environment for skin cancer prevention. In FY 2004, CDC funded state education agencies in Colorado, North Carolina and Michigan to implement skin cancer projects.

7. OVARIAN CANCER AND BLOOD CANCERS

GOALS (HEALTHY PEOPLE 2010)

- Reduce the overall cancer death rate.
- Increase the proportion of cancer survivors who are living five years or longer after diagnosis.

Current Activities and Significant Accomplishments

- The American Cancer Society estimates that about 25,580 new cases of ovarian cancer will be diagnosed in 2004 and 16,090 women will die. CDC has developed public health activities aimed at reducing ovarian cancer morbidity and mortality. To identify unmet public health needs, CDC convened a workshop in November 2000 with leaders from state health departments, ovarian cancer advocacy groups, physicians and scientists from Federal agencies, medical centers, and cancer treatment programs. Participants identified several priority public health activities and research needs. CDC is using this information to continue to guide research and health communication activities related to ovarian cancer.
- In FY 2004, CDC received \$5 million to establish and implement a program to provide information and education to patients and the general public concerning blood cancer. In FY 2004, CDC funded nine national organizations to conduct programmatic activities to promote blood cancer education and information dissemination on support services that serve a large number of blood cancer patients.

C. DIABETES PREVENTION AND CONTROL

Over 18 million Americans have diabetes, and the number of new cases is increasing steadily. In 1992 about 625,000 new cases were diagnosed; in 2002, there were over one million new cases. Even more disturbing, approximately five million of the 18 million people with diabetes in the U.S. do not know they have it. Diabetes is now the sixth leading cause of death in the U.S., and costs the nation nearly \$132 billion a year. Diabetes can cause heart disease, stroke, blindness, kidney failure, pregnancy complications, amputations of the leg, foot, and toe, as well as deaths related to flu and pneumonia. Particularly at risk are the five million Americans who are unaware that they have the disease. CDC further estimates that the number of Americans with diagnosed diabetes will increase from 11 million to 30 million between 2000 and 2050.

Recently released results from the largest-ever clinical study on diabetes prevention confirmed that diabetes can be prevented in high-risk adults. The CDC-supported lifestyle intervention component of the Diabetes Prevention Program (DPP) demonstrated that lifestyle intervention, including weight control and moderate physical activity, reduced the risk of diabetes by nearly 60 percent among overweight adults with impaired glucose tolerance, or pre-diabetes.

GOAL: INCREASE THE CAPACITY OF STATE DIABETES CONTROL PROGRAMS TO ADDRESS THE PREVENTION OF DIABETES AND ITS COMPLICATIONS AT THE COMMUNITY LEVEL BY INCREASING THE PERCENTAGE OF PERSONS WITH DIABETES WHO RECEIVE ANNUAL EYE AND FOOT EXAMS; AND AT LEAST TWO A1C MEASURES PER YEAR.

Current Activities

- CDC's National Diabetes Prevention and Control Program (DPCP) supports and promotes access to quality diabetes care and services for people with diabetes. CDC funds 59 diabetes prevention and control programs in states, the District of Columbia, and U.S. territories.
- In FY 2004, 24 states and the District of Columbia were funded at a capacity-building level (\$250,000). Twenty-six states were funded at a basic implementation level (\$725,000). Basic implementation programs develop and promote diabetes care standards for adoption in health care delivery settings; help state Medicaid programs develop and monitor quality outcome measures for diabetes care; launch public and physician education campaigns to promote improved understanding and regular use of tests to determine average blood sugar levels; and involve communities in diabetes control activities, such as walking programs. Evaluation data from several states indicate that significant improvements in preventive care practices (annual eye exams, blood glucose levels, foot exams, weight loss) are occurring as a result of these statewide interventions and programs.
- With increased funding in FY 2005, CDC will increase the number of basic implementation DPCPs and launch several state-based primary prevention pilots. CDC plans to fund an additional one to three states at the basic implementation level. The number of states to be promoted from capacity building to basic implementation will be based upon past performance and the strength of the state's revised workplan, and upon final estimated costs of the new state-based primary prevention pilots.

- Approximately 5 million people have diabetes and do not know it. People with undiagnosed diabetes include those without symptoms related to diabetes. It is believed that for many of these persons, earlier diagnosis and treatment can prevent or delay complications of diabetes. In FY 2004, HHS launched the Diabetes Detection Initiative (DDI) to help people understand their diabetes risk status and assist high-risk people in linking with various health care systems. After 12 intensive months of implementation, preliminary evaluation results indicate that the Diabetes Detection Initiative: increased the number of monthly finger sticks by about 40%; increased the number of newly diagnosed diabetes cases by an average of 13 cases per month; distributed approximately 800,000 customized risk tests, adapted from the American Diabetes Association (ADA), throughout communities in the 10 pilot sites; distributed approximately 500 health provider tools, "Information for Health Providers, Steps to Finding the Undiagnosed", to participating health centers and local area health providers; and awarded a companion economic evaluation of the DDI for completion by late 2005.

Significant Accomplishments

- The Louisiana Diabetes Prevention and Control Program partnered with the City of New Orleans Health Department's Healthcare for the Homeless Clinic to improve the clinic's ability to provide diabetes education to patients. The program seeks to improve patient compliance with treatment regimens. In June 2004, 99% of patients had at least one A1C check, and 54% had at least two A1C checks in the past year, compared with 15.75% and 25.5% in September 2001. By June 2004, 99.4% of patients had met diabetes self management goals compared with 94.1% in September 2001. This program is a successful example of how state programs can promote healthy behaviors and reduce needless disease and economic burden for homeless people with, or at risk for, diabetes.
- In FY 2003, the Missouri Diabetes Prevention and Control Program provided five Federally Qualified Health Centers with financial support, a local learning session, technical assistance on registry development and maintenance, health system redesign, monthly review of reports, and evaluation skills. The state diabetes program also evaluated aggregate data from the combined diabetes registries of the health centers participating in the Midwest Cluster of the National Diabetes Collaborative. Preliminary results indicate that from June 2000 to May 2003, the health centers significantly improved 12 of 16 diabetes care measures, including increases in the prevalence of at least two A1c tests at least three months apart (15%), dilated-eye examinations (190%), foot examinations (47%), influenza vaccinations (76%), and setting of self-management goals (37%).

D. TOBACCO USE PREVENTION

Tobacco use is the single most preventable cause of death and disease in the U.S.; it is responsible for approximately 440,000 deaths each year and more than \$150 billion annually in medical care costs and lost productivity. Every day, more than 6,000 young people try cigarettes for the first time. If current smoking trends continue, it is anticipated that one-third of these young smokers will die from a smoking-related disease. By 2030, the global tobacco epidemic will become the leading cause of preventable and premature death worldwide.

GOAL: REDUCE CIGARETTE SMOKING AMONG YOUTH.

Current Activities

- CDC funds tobacco control programs in all states, the District of Columbia, and seven U.S. territories. CDC also supports 15 organizations with access to diverse populations, including seven tribal organizations and eight national organizations. CDC's tobacco control program builds on the successes of programs conducted by the National Cancer Institute, CDC, and states that have funded tobacco control programs through excise taxes and lawsuit settlements.
- In FY 2004, CDC funded a national network of smoking cessation quitlines to provide smokers access to the support and latest information to help them quit. These funds were in addition to awards from CDC's Comprehensive State-Based Tobacco Use Prevention and Control Program. Forty-nine states, the District of Columbia, and five U.S. Territories are establishing state quitlines (capacity building) or enhancing existing quitlines (enhancement) within their states. A key component of the national network of quitlines is the establishment of a single, toll-free national number (1-800-QUIT NOW) that serves as a portal, linking callers to their state's telephone cessation services.

Significant Accomplishments

- In 2004, CDC published a study showing that cigarette use among adolescents in 2003 was at the lowest level since national surveys have been monitoring youth smoking. According to data from CDC's Youth Risk

Behavior Surveillance System, the percentage of students who reported current cigarette use decreased significantly from 36.4 percent in 1997 to 21.9 percent in 2003.

- In states where tobacco control programs consistent with CDC's guidelines have been implemented, dramatic results are evident. For example, as many states continued to cut funding for tobacco control due to fiscal crises, a study released in September 2003 found double the decrease in cigarette sales among states that spent more on comprehensive tobacco control programs than in the United States as a whole. Between 1990 and 2000, sales fell an average of 43 percent in four key states with large program expenditures – Arizona, California, Massachusetts, and Oregon – compared with 20 percent for all states. Program funding levels accounted for a substantial portion of the difference, above and beyond the effect of cigarette excise tax hikes, with increasing expenditures producing bigger and faster declines in cigarette sales.

E. NUTRITION AND PHYSICAL ACTIVITY PROGRAMS TO PREVENT OBESITY AND OTHER CHRONIC DISEASES

In the last ten years, obesity rates have increased by more than 60 percent in adults. Since 1980, rates have doubled in children and tripled in adolescents. Thirty-one percent of the adult population in the U.S. is obese or approximately 59 million adults. Almost 16 percent of our children and adolescents are overweight, or approximately nine million youth. Rates of obesity have increased more rapidly among African-Americans and Mexican-Americans than among Caucasians. Obesity in the U.S. is truly epidemic.

Physical inactivity and unhealthy eating contribute to obesity, cancer, cardiovascular disease, and diabetes. Together, they are responsible for thousands of preventable deaths each year. Despite the proven health benefits of physical activity, more than 50 percent of American adults do not engage in levels of physical activity necessary to provide health benefits. Insufficient physical activity is not limited to adults. More than a third of young people in grades nine to 12 do not regularly engage in vigorous physical activity.

GOAL: DECREASE LEVELS OF OBESITY, OR REDUCE THE RATE OF GROWTH OF OBESITY, IN COMMUNITIES THROUGH NUTRITION AND PHYSICAL ACTIVITY INTERVENTIONS.

Current Activities

- The purpose of the National Nutrition and Physical Activity Program to Prevent Obesity and Other Chronic Diseases is to support states in the development and implementation of evidence-based nutrition and physical activity interventions. With increased funding in FY 2005, CDC plans to move two states from the capacity-building level (\$450,000) to the basic implementation level (\$800,000), and increase funding for those states already funded (up to \$1.5M) at the basic implementation level. This will fund up to seven states at the basic implementation level to conduct nutrition and physical activity interventions through population-based strategies, such as policy-level change, environmental change, and social marketing. Twenty one states will receive funds for capacity-building programs.
- CDC also conducts prevention research and health tracking. For example, an economic study of the medical costs of obesity in the U.S. co-authored by CDC found that direct medical cost related to overweight and obesity accounted for nine percent of total medical expenditures in 1998, and that more than half of these costs were borne by Medicaid and Medicare. In FY 2004, CDC drafted recommendations for preventing and controlling obesity in the Guide to Community Preventive Services. Also, CDC is examining the role of fruit and vegetable consumption in managing weight.

Significant Accomplishments

- North Carolina developed a Nutrition and Physical Activity Surveillance System (NC NPASS) to help the state develop and improve interventions, and engage communities and policymakers.
- Intervention evaluations in the Massachusetts 5-2-1 Go! program showed: 1) how characteristics of the built environment affect youth's ability to walk to school and 2) that higher rates of vending machine and fast-food restaurant use among students are associated with higher sugar-sweetened beverage consumption.
- Nationally, the Program developed two new tools to help states develop, evaluate, and improve their programs: 1) the Progress Monitoring Report (PMR), now a Web-based system that facilitates the collection of information from states and 2) the State Plan Index (SPI), providing a template for states to develop new plans and revise existing ones.
- WISEWOMAN is having a positive impact in the lives of underserved women. Each of the past four years, the number of women served has doubled for a total of more than 30,000. The program has provided more than 67,000 lifestyle interventions. In 2003, 12,000 women were screened. For women followed in 2003,

cholesterol levels dropped from 213 milligrams per deciliter to 210, and their risk of a heart attack in the next five years decreased. As a result we have seen improvements in women's cardiovascular health profile.

F. SAFE MOTHERHOOD/INFANT HEALTH PROGRAMS

Maternal mortality has not decreased in the U.S. in the last 20 years. The U.S. ranks 30th among developed countries in maternal mortality. About one in four women, or one million per year, will have serious complications during labor. For every 100,000 infants born in the U.S., approximately 12 women will die of pregnancy-related causes or complications. African-American women continue to have four times the risk of dying from pregnancy complications than Caucasian women.

GOALS

- To promote optimal reproductive and infant health and quality of life.
- To reduce the incidence of pregnancy-related illness and death.
- To examine racial disparities in pregnancy-related death rates.

Current Activities

CDC funds 29 states and New York City to conduct the Pregnancy Risk Assessment Monitoring System (PRAMS), representing 62 percent of U.S. births. PRAMS collects information on pregnancy-related morbidity, access to and use of prenatal care, physical violence during pregnancy, obstetric history and nutrition, alcohol and tobacco use during pregnancy, infant health care, infant sleeping position, and economic status of the mother.

Significant Accomplishments

- A study by the Colorado Department of Public Health used 1998 PRAMS data to examine the level of prenatal care and selected birth outcomes among documented and undocumented immigrant women in Colorado. Undocumented women could not receive prenatal care through Medicaid, but could receive emergency care for labor and delivery. The results of the study described the lack of prenatal care and the higher rate of negative birth outcomes among undocumented women. As a result, the Colorado state legislature passed a bill in the 2000 session allowing undocumented women to enroll in a Medicaid health maintenance organization and receive prenatal care at any time during pregnancy.
- CDC presented information on risk factors for Sudden Infant Death Syndrome (SIDS) to the Louisiana SIDS Steering Committee. As a result, the Committee decided to develop a statewide media campaign to increase awareness of risk factors associated with SIDS. The campaign is currently being developed by the Maternal and Child Health Department of the Louisiana State Office of Public Health.
- CDC revised the 1996 Guidelines for Death Scene Investigation of Sudden Unexplained Infant Death and the Sudden Unexplained Infant Deaths Investigation Report Form. Final revisions will be complete in summer 2005.

G. ARTHRITIS AND OTHER CHRONIC DISEASES

Arthritis is the nation's leading cause of disability, limiting daily activities for more than eight million citizens. Arthritis encompasses more than 100 diseases and conditions that affect joints and surrounding connective tissues. In 2002, 43 million adults reported their doctor told them they had arthritis – nearly one of every four adults – making it among the most common health problems in the U.S. An additional 23 million Americans reported chronic joint pain.

CDC, the Arthritis Foundation, and other partners are working to implement the National Arthritis Action Plan: A Public Health Strategy. CDC is working to further enhance the infrastructure to address arthritis as a public health problem, improve the science base, increase awareness of the impact of arthritis and appropriate management of the disease, and develop and evaluate programs that improve the quality of life among persons with arthritis.

GOALS (HEALTHY PEOPLE 2010)

- Increase the quality of life among persons with arthritis:
 - Long term, decreasing pain and disability and improving physical, psychosocial and work function.
 - Short term, increasing early diagnosis and appropriate management, and improving self-management attitudes and behaviors.

Current Activities

CDC funds 36 states to initiate or enhance public health activities for arthritis. States, with their partners, are implementing activities in their state action plans, such as conducting the CDC health communication campaign and providing interventions in selected populations.

Significant Accomplishments

- CDC is developing an arthritis-specific national survey to address arthritis issues in more detail (Arthritis Conditions and Health Effects Survey).
- CDC funded two states (Georgia and Michigan) to implement a population-based registry for lupus.
- CDC developed and rolled-out a health communications campaign, *Physical Activity. The Arthritis Pain Reliever*, which targets low income African-American and Caucasian people age 45-64. CDC is currently developing and testing materials for a Hispanic version of the health communications campaign.

H. ORAL HEALTH PROGRAMS

Despite dramatic declines in dental disease rates for over the past 20-30 years, dental caries (tooth decay) remain a significant problem for U.S. children and adults. Tooth decay afflicts more than 67 percent of children by the time they are 19 years old and more than 90 percent of Americans 20 years and older. Over 20 percent of Americans of all ages have some untreated decay. Among children from the poorest families, almost one third of tooth decay is untreated.

Children receiving dental sealants or protective coatings on the chewing surfaces of teeth, in school-based or linked programs have 60 percent fewer new decayed chewing surfaces in back teeth for up to five years after they are applied.

GOALS (HEALTHY PEOPLE 2010)

- Increase the number of schools with high-risk children that are served by school-based/linked dental sealant programs.
- Increase the proportion of children who have received dental sealants on their permanent molar teeth.
- Increase the proportion of the U.S. population served by community water systems with optimally fluoridated water.

Current Activities

CDC is the Federal agency with primary responsibility for supporting state and community programs to prevent oral disease, promote oral health nationwide, monitor oral health status and behaviors, provide guidance of safer office infection control practice, and foster applied research to document the efficacy and efficiency of community-based programs and provide tools that can assist programs.

CDC funds 12 states and one territory for capacity building activities aimed at strengthening their oral health programs and reducing inequalities in the oral health of their residents. Additional funds are being provided to some of these states to build capacity for two proven disease prevention strategies, community water fluoridation and school-based or linked dental sealant activities.

Significant Accomplishments

- CDC provided technical assistance to states to extend optimally fluoridated drinking water to more Americans. CDC established a Water Fluoridation Reporting System, which provides updated reports of state water fluoridation status and supports quality assurance activities. A recent update shows that two-thirds (67 percent) of U.S. residents on public water systems now receive fluoridated water, approximately 100 million Americans still do not receive its benefits.
- CDC pilot funding to the Wisconsin Department of Public Instruction and the Department of Health and Family Services provided support for Healthy Smiles for Wisconsin, a state-wide effort to improve the oral health of Wisconsin children through school and community partnerships. Activities included formation of the Healthy Smiles for Wisconsin Coalition, whose *Seal A Smile* initiative facilitated 40 new community-based dental sealant programs organized through the schools during the 2000-2004 school years.
- CDC published *Guidelines for Infection Control in Dental Health-Care Settings*. This document updates previous CDC recommendations, and sets the standard for dental office infection control practice both in the

United States and throughout the world. The Guidelines are being distributed to practitioners, dental and allied dental education programs, state boards of dental examiners, and dental laboratories.

I. BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM (BRFSS)

Health tracking is the essential underpinning for all public health efforts. It provides the information necessary to define the disease burden, identify populations at highest risk, and guide and evaluate disease prevention efforts at national, state, and local levels.

GOAL: ASSIST STATES IN MONITORING THE PREVALENCE OF MAJOR BEHAVIORAL RISKS ASSOCIATED WITH PREMATURE MORBIDITY AND MORTALITY IN ADULTS TO IMPROVE THE PLANNING, IMPLEMENTATION, AND EVALUATION OF HEALTH PROMOTION AND DISEASE PREVENTION PROGRAMS.

Current Activities

The BRFSS is the nation's premier system for measuring, at the state level, critical health problems and a wide range of health-related behaviors in the U.S. adult population. Active in all 50 states, the District of Columbia, Puerto Rico, Guam, and the U.S. Virgin Islands, BRFSS is the primary source of information on major health risk behaviors of American adults. BRFSS provides timely and ongoing data collection that is flexible in order to meet individual state needs. CDC provides funding, consults with state staff, edits and processes the data from each state's monthly interviews, and returns to states prevalence information and reports for their use.

Significant Accomplishments

- SMART BRFSS (Selected Metropolitan/Micropolitan Area Risk Trends from the BRFSS) was released in November 2003. This is the first time that health officials have had access to local-level data on health risk behaviors that are comparable across the nation. Small area estimates will continue to be produced using SMART BRFSS methodology for data years subsequent to 2003.
- BRFSS data are the source for important public health messages, such as the obesity and diabetes epidemic trend maps.
- BRFSS was quickly modified to incorporate questions relating to the influenza vaccine shortage emergency for the 2004-2005 flu season.

J. SCHOOL HEALTH PROGRAMS

1. COORDINATED SCHOOL HEALTH PROGRAMS

Extending the eight components of school health – health education, physical education, health services, nutrition services, counseling, psychological and social services, healthy school environment, health promotion for staff, and family and community involvement to all American children through coordinated school health programs is the major focus of future CDC efforts to improve the health of young people and the adults they will become.

GOAL: INCREASE THE PROPORTION OF MIDDLE, JUNIOR HIGH AND SENIOR HIGH SCHOOLS THAT PROVIDE SCHOOL HEALTH EDUCATION TO PREVENT HEALTH PROBLEMS IN THE FOLLOWING AREAS: UNINTENTIONAL INJURY, VIOLENCE, SUICIDE, TOBACCO USE AND ADDICTION, ALCOHOL AND OTHER DRUG USE, UNINTENDED PREGNANCY, HIV/AIDS, AND STD INFECTION, UNHEALTHY DIETS, INADEQUATE PHYSICAL ACTIVITY, AND ENVIRONMENTAL HEALTH.

Current Activities

In FY 2005, CDC is funding 23 states for Coordinated School Health Programs that reduce chronic disease risk factors such as poor eating habits, physical inactivity, and tobacco use. CDC provides tools to states that strengthen and improve local programs. Through monitoring of youth risk behaviors and school health programs, science-based guidance, and support of program implementation and evaluation, CDC contributes to improvements in the quality of school health programs and policies.

Significant Accomplishments

- The proportion of secondary schools that are fully tobacco free increased from 37 percent in 1994 to 46 percent in 2000 and a large and growing number of schools have recently improved the nutritional quality of food and beverage items sold in vending machines. School health policies and programs have contributed to recent decreases in health risk behaviors among high school students, including the decline in cigarette smoking rates from 36 percent in 1997 to 22 percent in 2003.

- CDC performed an economic evaluation of school programs to prevent cigarette use among middle and high school students. This study showed that for every dollar invested in school tobacco prevention programs, almost \$20 in medical care costs would be saved.
- CDC conducted an economic analysis of a school-based obesity prevention program which found that at an intervention cost of \$33,677 or \$14 per student per year, the program would prevent an estimated two percent of the female students from becoming overweight adults. As a result, society could expect to save an estimated \$16,000 in medical costs and \$25,000 in loss of productivity costs.

2. HIV PREVENTION AMONG SCHOOL-AGED YOUTH

Young adults are contracting HIV/AIDS at a faster rate than any other age group. About 53 million young people attend more than 119,000 schools across our nation. Because of the size and accessibility of this population, school health programs are one of the most efficient means of preventing new HIV infections among young people. Scientific evaluations of school-based HIV prevention programs have shown that these programs are cost-effective and decrease sexual risk behaviors among high school students. These same studies show that the programs do not increase sexual activity among students.

GOAL: REDUCE THE PERCENTAGE OF HIV/AIDS-RELATED RISK BEHAVIORS AMONG SCHOOL-AGED YOUTH THROUGH DISSEMINATION OF HIV PREVENTION EDUCATION PROGRAMS.

Current Activities

In response to this high rate of infection, CDC funds 48 states, seven territories, and 18 large city education agencies for school health programs to provide young people with skills and information to avoid behaviors that put them at risk for HIV infection. CDC also supports training for teachers and other school personnel to implement HIV prevention education in schools.

Significant Accomplishments

- Between 1991 and 2003, the percentage of high school students who ever had sexual intercourse decreased from 54%-47%; the percentage who used a condom at last intercourse rose from 46%-63%; the percentage who had multiple sex partners decreased from 19%-14%; and the percentage who had been taught about HIV and AIDS in school rose from 83%-88%.
- A recent cost effectiveness study sponsored by CDC, revealed that for every dollar invested in school HIV, STD, and pregnancy prevention efforts, \$2.65 in medical and social costs were saved.
- To involve parents and the community in their school-based HIV/STD prevention efforts, a nationally recognized partnership between the Michigan Department of Education and Michigan PTA engages parents and educators in more than 100 communities to focus on how they can work together to strengthen their school-based HIV/STD prevention education programs.

K. PREVENTION RESEARCH CENTERS (PRCs)

PRCs are a network of academic centers, public health agencies, and community partners researching strategies for preventing and controlling chronic disease. In FY 2005, CDC is funding 33 PRCs (located in 26 states) that conduct about 500 research projects.

GOAL: SUPPORT PREVENTION RESEARCH TO DEVELOP SUSTAINABLE AND TRANSFERABLE COMMUNITY-BASED INTERVENTIONS.

Current Activities

PRC research addresses topics such as, nutrition and physical activity in preventing obesity, diabetes and heart disease; promoting healthy aging; healthy youth development, including prevention of violence and substance abuse, strengthening family and community relationships to support healthy lifestyles; controlling cancer risk and other health disparities.

Significant Accomplishments

- PRCs address one of our most pressing health issues: childhood obesity. The Harvard University Prevention Research Center developed an interdisciplinary curriculum (called Planet Health) for public middle schools focused on increasing consumption of fruits and vegetables, decreasing consumption of high-fat foods, decreasing television viewing, and increasing physical activity. Results yielded a significant reduction in television watching for both girls and boys, and a significant decrease in the prevalence of

obesity among girls. The Planet Health curriculum has been adopted by hundreds of middle schools in the Boston area and 2,000 copies of the curriculum have been purchased by interested parties in 48 states and 20 countries. An independent economic analysis found that every dollar spent on the program in middle school translated to a savings of \$1.20 in medical costs and lost wages when the children reach middle age.

- The University of Washington Health Promotion Research Center focuses on healthy aging. In 1993, the center collaborated with the Group Health Cooperative of Puget Sound and Senior Services of Seattle/King County to develop a physical activity program for seniors. The program emphasizes activities to increase endurance, strength, balance, and flexibility. The pilot study showed that participants improved significantly in almost every area tested – from physical and social functioning to levels of pain and depression. A recent economic analysis of Medicare enrollees showed that those participating in the Lifetime Fitness Program at least once per week had significantly fewer hospitalizations (by 7.9%), and lower healthcare costs (by \$1,057) than non-participants. The program is now being offered at 64 community sites in six states. The National Council on Aging recognizes the program as one of the top 10 physical activity programs for U.S. seniors.

L. YOUTH MEDIA CAMPAIGN

The Youth Media Campaign (YMC) is a national multi-ethnic media campaign that promotes regular physical activity among tweens (9-13 years). Secondary audiences are parents plus teen and adult influencers. The campaign's brand, *VERB™*. *It's what you do*, was launched in June 2002. Full launch of all campaign components occurred in mid-October 2002.

GOAL: TO INCREASE AND MAINTAIN REGULAR PHYSICAL ACTIVITY AMONG TEENS AGES 9-13.

Current Activities

In FY 2005, CDC will continue the VERB campaign and will also receive (in-kind) commitments from our media partners. These in-kind contributions include strategic marketing initiatives such as: *Make Every Move Count*, an in-school program to get kids active, *Play Your Way* initiative with Disney that includes TV vignettes, radio, print and internet support, *WB VERB Music CD*, *Sports Illustrated for Kids Road Trip* sponsorship, and *Time for Kids In-School* program. These in-kind marketing programs leverage the use of our partners' brands and strong loyalty with the target audience to elevate *VERB* to the highest level.

Significant Accomplishments

- Year one evaluation results show the VERB™ campaign is motivating youth to get active – The award winning, multicultural campaign known as VERB™ had one of the largest effects, a 34 percent increase, in weekly free-time physical activity self reported sessions among 8.6 million children ages 9-10 in the U.S.
- In communities that received higher levels of VERB™ marketing activity, the increases in physical activity were even more dramatic. CDC found that the number of least active 9-10 year olds was reduced by 33 percent as a result of the VERB™ campaign. The number of least active 9-13 year old girls decreased even more, by 37%, in these communities. There was a 38 percent decline among least active 9-13 year olds from lower-middle income households.
- Preliminary year two awareness evaluation data show continued success of the campaign. A high awareness of VERB has been maintained among the original group of 9-13 year old tweens surveyed nationally who are now ages 11-15 years. Eighty five percent of tweens were aware of VERB, including 55% who had unaided awareness (spontaneous mention of VERB). This is 10% and 38% higher, respectively, compared to year one awareness levels.
- CDC surveyed a new group of tweens currently ages 9-13 years in 2004, in addition to the original group. This new cross-sectional sample is likely a more accurate reflection of current national awareness of VERB among tweens because they are in the campaign's target age range and have not been biased by being surveyed previously. Seventy-four percent were aware of VERB, including 21% who had unaided awareness.
- Year two behavior effects of the campaign findings will be available in Spring 2005.

M. STEPS TO A HEALTHIERUS

Steps to a HealthierUS is an initiative of the U.S. Department of Health and Human Services (HHS) that advances President George W. Bush's *HealthierUS* goal of helping Americans live longer, better, and healthier lives.

A centerpiece of this initiative is the five-year cooperative agreement program that combines the strengths and resources of all relevant HHS agencies and programs to improve the lives of Americans through innovative, community-based programs that are proven effective in preventing and controlling chronic disease. Through this program, communities, cities, and tribal entities receive funds to implement chronic disease prevention efforts focused on reducing the burden of diabetes, overweight, obesity, and asthma and addressing three related risk factors – physical inactivity, poor nutrition, and tobacco use.

GOALS

- Prevent Americans from developing diabetes.
- Prevent Americans from developing obesity.
- Prevent Americans from being hospitalized for asthma.

Current Activities

The FY 2003 initiative distributed \$13.6 million to 12 grantees, representing 24 communities. Funds went to seven large cities, one tribe, and four states that coordinate grants to 16 small cities and rural communities. In FY 2004, \$35.8 million was granted to increase funding to existing communities and fund an additional ten grantees representing 16 communities (five large cities, two tribes, and three states that coordinate grants to nine small cities and rural communities). These 40 communities are implementing community action plans that build on existing local, state, and federal programming efforts related to obesity, diabetes, asthma and their risk factors and include a special focus on populations with disproportionate burden of disease and disparities in preventive services. Organized community, environmental, educational, media, and policy interventions are being implemented in school, community, health care and workplace settings.

In addition, in FY 2004 the Steps Program funded the YMCA for a four year cooperative agreement grant. The YMCA will help increase the capacity and impact of the Steps community grantees through conferences, minigrants, and formal partnerships with local YMCAs. .

With increased resources in FY 2005, HHS will:

- Maintain funding for the FY 2003 grantees (average award for cities: \$2 million, average award for states: \$2.8 million, award for tribal consortiums: \$800,000).
- Increase grant amounts for the FY 2004 grantees (average award for cities: \$1.5 million, average award for states: \$2 million; award for tribal consortiums: \$800,000).

Significant Accomplishments

All Steps-funded communities are required to implement chronic disease prevention strategies in all six of the following topic areas: obesity, diabetes, asthma, poor nutrition, physical inactivity, and tobacco use:

- The Philadelphia Steps Faith Based Coalition worked with Keystone Mercy Health Plan, Thomas Jefferson University Hospital and the North Philadelphia SDA Church to provide a special four-week, 16-session diabetes initiative. Fifty African Americans with diabetes and 20 pre-diabetics achieved glucose levels within normal limits in less than four weeks through participation in the program.
- The Salinas/Monterey County Steps program used funds to implement the American Lung Association's Open Airways for Schools in all Salinas schools. Open Airways is a curriculum-based activity that provides students with specific asthma self-management skills and positive reinforcement from teachers and asthma education instructors.

N. RACIAL AND ETHNIC APPROACHES TO COMMUNITY HEALTH (REACH) 2010

There are continuing disparities in the burden of illness and death experienced by African Americans, Hispanics, American Indians, Alaska Natives, Asian Americans, and Pacific Islanders compared to the U.S. population as a whole. For example, rates of death from diseases of the heart are 30 percent higher among African Americans than among whites and rates of death from stroke are 41 percent higher. The prevalence of diabetes is about 1.6 times higher among African Americans and 1.5 times higher among Hispanics than among non-Hispanic white Americans of similar age. Although African Americans and Hispanics represent only 26 percent of the country's population, more than 68 percent of the AIDS cases reported to CDC have been among these minority populations; for children, the contrasts are even more dramatic, with African-American and Hispanic children representing 90 percent of pediatric AIDS cases.

The demographic changes that are anticipated over the next decade amplify the importance of addressing disparities in health status. Racial and ethnic groups will increase in upcoming decades as a proportion of the total U.S. population; therefore, the future health of America will be influenced substantially by our success in improving the health of these populations. A national focus on disparities in health status is particularly important as changes unfold in the delivery and financing of healthcare.

REACH 2010 supports racial and ethnic minority communities in designing, implementing, and evaluating community-driven strategies that will contribute to the elimination of health disparities in the following six target health areas: diabetes, infant mortality, breast and cervical cancer screening and management, cardiovascular disease, HIV infection and AIDS, and child and adult immunizations. Target populations are African-Americans, American Indians, Hispanic-Americans, Asian-Americans, Pacific Islanders, and Alaska Natives.

GOAL: BY 2010, IMPROVE THE LIVES OF RACIAL AND ETHNIC POPULATIONS WHO SUFFER DISPROPORTIONATELY FROM THE BURDEN OF DISEASE AND DISABILITY, AND DEVELOP TOOLS AND STRATEGIES THAT WILL ENABLE THE NATION TO ELIMINATE THESE HEALTH DISPARITIES.

Current Activities

CDC funds 40 communities (including four elderly projects) to carry out community action plans for the implementation and evaluation of REACH 2010. Five American Indian and Alaska Native communities are funded through capacity-building grants. CDC will continue to support two evaluation contractors to provide qualitative and quantitative assessments of the REACH 2010 program. Some examples of REACH 2010 project activities are:

- Improving access to health care by locating permanent sources of health care closer to underserved communities; establishing breast cancer education programs in senior centers and retirement communities; reducing financial barriers to community member participation in physical activity; increasing access to low-cost or free early and adequate prenatal care; and establishing and supporting peer educator programs in youth organizations, middle schools, and high schools to encourage healthy living skills.
- Addressing diabetes by providing guides in local restaurants that describe the healthy meal alternatives offered; distributing low-fat menus and recipes at local supermarkets tied to current sales items offered by local retailers; and offering awareness seminars about Type 2 diabetes at churches, local senior centers and retirement communities. A specific example of an approach is the use of Promotoras (health promoters). The Promotoras not only serve the community as health educators and advocates, but also are developed to be community leaders as they gain experience in community organizing, program planning, and program evaluation.
- Addressing infant mortality by awarding grants to agencies that will provide training and services in pre-conception counseling to reduce risk for low birth weight and infant death. Creative approaches include work in the field of collective memory of racism in research and health as it influences health care system use by African-Americans. The grantee addresses hard questions of racism by providing “undoing racism” workshops which provide the opportunity to take an in-depth look at racism, what racism is, and why it still exists.
- Providing incentives to women who routinely get mammography and Pap smear tests to address breast and cervical cancer. One project uses a faith-based approach to improving breast and cervical cancer screening and management. Several interventions are used to accomplish project goals, including: 1) church-based education conducted by trained lay health workers recruited from the churches, 2) increased access and utilization of screening services, 3) screening promotion through media broadcasts to access those who do not attend church, and 4) outreach to other stakeholders in the community through grassroots advocacy to improve access to health care resources.
- Developing an HIV prevention curriculum for youth in conjunction with existing youth programs; using media to reach men, women, and children; increasing outreach to men and women; training for women around gender and power dynamics; training for couples; training faith organizations, business, and media leaders; conducting outreach strategies that encourage prophylaxis treatment for pregnant women living with AIDS; and, increasing outreach to encourage community members to return for their HIV test results.
- Addressing immunization of children through: 1) a provider-based intervention called Assessment, Feedback, Incentives and Exchange (AFIX) to improve practices in and access to public clinics, nonprofit clinics and private physician practices, and 2) community-based interventions to conduct outreach to under-immunized children identified from public and nonprofit clinics. These are being complemented by outreach and referrals for children without a medical home or insurance, cultural competency training for providers, and formation of a Child Health Services Network.

Significant Accomplishments

- Working with communities, REACH 2010 continues to demonstrate that health disparities can be reduced and that significant progress can be made in improving health in communities of racial and ethnic minority groups. For example, engaging a variety of community-based, religious, grassroots, and health care organizations, the University of Alabama at Birmingham virtually eliminated disparities in use of mammography screening for early detection of breast cancer in one community. In Macon County, Alabama, disparity in use of mammography screening was reduced from 15 percent in 1998 to two percent in 2003.
- In South Carolina, two communities are focusing on improving the health care system for the care of persons diagnosed with diabetes. Following 12 months of implementation, disparities in A1C (blood sugar) testing have decreased from 15 percent to two percent and disparities in lipid testing from 28 percent to 11 percent. This partnership between the clinics and the REACH team has fostered a positive relationship to improve the overall care of patients diagnosed with diabetes.
- *Ethnicity and Disease*, the official journal of the International Society on Hypertension in Blacks, published a special supplement examining the prevention strategies implemented by 15 of the 40 communities that participate in the REACH 2010 program.

O. GENOMICS AND DISEASE PREVENTION

The genomics activity at CDC is responsible for the translation of genomic research into opportunities for public health and preventive medicine, and provides national public health leadership and builds partnerships with other Federal agencies, public health organizations, professional groups, and the private sector.

Current Activities

CDC's genomics program has established Centers for Genomics and Public Health at three schools of public health at the University of Michigan, the University of North Carolina and the University of Washington. These Centers have contributed to the knowledge base for genomics and population health and built regional hubs of expertise for collaboration with state and local health departments.

In 2002, CDC launched a public health initiative to evaluate the use of family history information to assess risk for common diseases and influence early detection and prevention strategies. The Family History Public Health Initiative includes analysis of existing datasets to fill gaps in knowledge about validity and utility of the family history approach; development of a family history data collection tool and a resource manual for health care providers; creation of pilot studies and funding opportunities for evaluating the tools and eventually for evaluating public health campaigns; and physician education programs. A national working group was formed to provide guidance and expertise for the many components of the research initiative. The multidisciplinary working group includes representatives from CDC, NIH, other Federal agencies, state public health programs, academia, and the health care community.

A new project initiated in 2004 is Evaluation of Genomic Applications in Practice and Prevention (EGAPP). The goal is to develop and evaluate a coordinated process for systematic assessment of genetic tests in transition from research to clinical and public health practice in the United States. Key elements for achieving success will be engaging stakeholders (e.g., health care providers, consumers, policy makers, health care purchasers and payers) and developing collaborations with existing appraisal processes (e.g., U.S. Preventive Services Task Force), other HHS agencies, the international health technology assessment community, and other relevant projects and advisory groups.

Significant Accomplishments

- *Six Weeks to Genomics Awareness*, an on-demand, Web-based course, was created by the Michigan Center for Genomics and Public Health, in collaboration with CDC, the Chronic Disease Directors, and the University of North Carolina and University of Washington Centers for Genomics and Public Health. It is designed to provide public health professionals with a foundation for understanding genomic advances and identifying the relevance of genomics to public health.
- *Family Healthware* is a Web-based, prototype family history tool created for the Family History Public Health Initiative. *Family Healthware* will be pilot-tested in a variety of public health and preventive medicine settings. CDC has awarded funding to three research centers—the University of Michigan School of Medicine, Evanston Northwestern Healthcare Research Institute, and Case Western Reserve University School of Medicine—for a collaborative study set in primary care clinics. The study will determine whether family history risk assessment, classification, and personalized prevention messages influence health behaviors and the use of preventive medical services.

RATIONALE FOR THE BUDGET

The FY 2006 budget request of \$840,858,000 for Chronic Disease Prevention, Health Promotion and Genomics represents a decrease of \$58,599,000 below the FY 2005 Enacted level of \$899,457,000. This includes the restoration of an FY 2005 Labor/HHS/Education reduction of \$417,000.

VERB™. IT'S WHAT YOU DO - YOUTH MEDIA CAMPAIGN (-\$58,795,000)

The FY 2006 budget request reflects the elimination of the *VERB™. It's what you do - Youth Media Campaign*. The Youth Media Campaign was authorized for five years in FY 2001 to communicate messages clearly to help kids develop habits fostering good health, including promoting mental health over a lifetime and addressing the growing problem of obesity in this country. The VERB Campaign has been a tremendous Federal project since its inception in 2002. The VERB Program was not intended to be a long-term national program, and funding has yielded many good results, as well as an excellent example of how effective partnerships with private industry can leverage limited government funds.

IT REDUCTION

Funding for the Chronic Disease Prevention, Health Promotion and Genomics activity includes an information technology savings of \$221,000.

OUTPUT TABLE

OUTPUT TABLE	FY 2004 ACTUAL	FY 2005 APPROPRIATION	FY 2006 ESTIMATE	FY 2006 +/- FY 2005
Heart Disease and Stroke				
States funded for capacity-building CVD prevention programs (includes DC)	21	19	19	0
States funded for basic implementation CVD prevention programs	12	14	14	0
Surveillance and research studies describing the CVD burden and developing effective intervention strategies	21	21	21	0
State health departments funded for ongoing state stroke registries to assess stroke treatment and improve the quality of care for acute stroke patients	4	4	4	0
Cancer Prevention and Control				
States funded for Comprehensive Cancer Control (includes 5 tribes and tribal organizations, the District of Columbia and 6 territories)	61	61	61	0
Cancer Registry states/territories with capacity-building programs	4	3	3	0
Cancer Registry states/territories with basic implementation programs	45	46	46	0
Cancer Registry Programs submitting data to the NPCR Cancer Surveillance System	47	48	48	0
Education campaign to promote colorectal cancer screening	1	1	1	0
Number of breast and cervical cancer screening programs	68	68	68	0
Number of states, territories, AI/AN tribes provided consultation and scientific expertise to support screening programs	68	68	68	0

NARRATIVE JUSTIFICATIONS
HEALTH PROMOTION
CHRONIC DISEASE PREVENTION, HEALTH PROMOTION, AND GENOMICS

OUTPUT TABLE	FY 2004 ACTUAL	FY 2005 APPROPRIATION	FY 2006 ESTIMATE	FY 2006 +/- FY 2005
Number of cooperative agreements to national partners and professional societies to promote cancer prevention	17	17	17	0
Diabetes				
Number of state-based Diabetes Prevention & Control Programs: Capacity-building (including DC)	25	22-24	22-24	0
Number of state-based Diabetes Control Programs: Basic Implementation	26	27-29	27-29	0
Number of territories/jurisdictions funded for capacity-building Diabetes Control Programs	8	8	8	0
Health education programs/ community interventions targeting minority populations	5	5	5	0
Number of childhood diabetes surveillance systems	6	6	6	0
Number of prevention research pilot projects for the primary prevention of diabetes	3	5	5	0
Health Promotion				
Number of state tobacco prevention and control programs (includes Washington, DC)	51	51	51	0
Tobacco Cessation Quitlines – States/Territories/Tribes funded to implement quitlines	19	19	19	0
Tobacco Cessation Quitlines – States/Territories/Tribes funded to enhance existing quitlines	36	36	36	0
Number of cooperative agreements for tobacco prevention with key organizations with access to diverse population	16	16	16	0
Scientific, technical, and public inquiry response on tobacco use	133,000	50,000	50,000	0
Total state health departments and other organizations (e.g., local health departments) requesting advertising campaign materials through the Media Campaign Resource Center	250	250	250	0
New methods to measure constituents in tobacco or tobacco smoke	4	4	4	0
Countries in which Global Youth Tobacco Survey have been implemented	140	163	163	0
Number of states implementing intervention programs for nutrition/PA/obesity	28	28	28	0
Number of state and tribal WISEWOMAN programs	15	15	15	0
Projects funded to conduct PRAMS	32	30	30	0
States with Maternal and Child Health (MCH) epidemiologist	16	16	16	0
Research projects in MCH	2	2	2	0

NARRATIVE JUSTIFICATIONS
HEALTH PROMOTION

CHRONIC DISEASE PREVENTION, HEALTH PROMOTION, AND GENOMICS

OUTPUT TABLE	FY 2004 ACTUAL	FY 2005 APPROPRIATION	FY 2006 ESTIMATE	FY 2006 +/- FY 2005
States funded for capacity-building arthritis programs	36	36	36	0
Number of population-based registries to define and monitor the incidence and prevalence of lupus	1	2	2	0
States/territories receiving support for capacity-building oral health prevention programs (e.g., fluoridation, sealants)	13	13	13	0
Number of vision screening initiatives	1	1	1	0
School Health Programs				
State education agencies working with state health departments to integrate prevention activities targeting tobacco use, sedentary lifestyles, poor eating habits into school health programs	23	23	23	0
Interventions identified to prevent HIV & chronic disease risk factors among youth	5	5	5	0
State, territory, and city education agencies working with state health departments to implement HIV education prevention in schools	73	73	73	0
Prevention Centers				
Prevention Research Centers with formal collaborative relationships with state and local agencies	33	33	33	0
Youth Media Campaign				
Maintain an interactive Web site for teens	1	1	0	(1)
Direct interaction with 2 million tweens (9-13 years) across the nation to undertake physical activity as a result of promotional programs	1	1	0	(1)
Number of paid print media advertisements insertions	50	35	0	(35)
Number of paid TV spots	1,900	1,300	0	(1,300)
Number of targeted marketing and communications activities in communities with high percentages of racial and ethnic minority populations	15	25	0	(25)
Number of programs in schools and through community organizations to increase physical activities among teens	4	4	0	(4)
Steps to a HealthierUS				
Number of local health depts. to fund large city and urban communities	12	12	12	0
Number of state health depts. to fund state-coordinated small city and rural communities (each state funds an average of 4 communities)	7	7	7	0
Number of tribal organizations	3	3	3	0
National Organizations	1	1	1	0

NARRATIVE JUSTIFICATIONS
HEALTH PROMOTION
CHRONIC DISEASE PREVENTION, HEALTH PROMOTION, AND GENOMICS

OUTPUT TABLE	FY 2004 ACTUAL	FY 2005 APPROPRIATION	FY 2006 ESTIMATE	FY 2006 +/- FY 2005
Eliminating Racial and Ethnic Health Disparities (REACH 2010)				
Implementation and evaluation phase projects in minority communities	31	31	31	0
REACH elderly projects	4	4	4	0
American Indian/Alaska Native communities participating in REACH	5	5	5	0

FUNCTIONAL TABLE

Chronic Disease Prevention, Health Promotion, & Genomics Budget by Functional Activity (Dollars in Thousands)	FY 2004 Actual	FY 2005 Enacted	FY 2006 Estimate	FY 2006 +/- FY 2005
Heart Disease and Stroke	\$41,628	\$44,618	\$44,627	\$10
Diabetes Prevention and Control	\$59,957	\$63,457	\$63,471	\$14
Cancer Prevention and Control	\$293,825	\$309,705	\$309,778	\$73
Arthritis and Other Chronic Diseases	\$22,022	\$22,487	\$22,493	\$5
Tobacco	\$90,239	\$104,345	\$104,370	\$25
Nutrition, Physical Activity, and Obesity	\$39,289	\$41,930	\$41,939	\$9
Health Promotion	\$20,620	\$21,635	\$21,640	\$5
School Health	\$57,232	\$56,746	\$56,759	\$13
Safe Motherhood/Infant Health	\$45,121	\$44,738	\$44,748	\$11
Oral Health	\$10,643	\$11,204	\$11,207	\$3
Prevention Research Centers	\$24,944	\$29,690	\$29,697	\$7
Youth Media Campaign	\$32,060	\$58,795	\$0	(\$58,794)
Steps to a Healthier U.S.	\$41,261	\$46,601	\$46,612	\$11
Racial and Ethnic Approach to Community Health	\$34,800	\$34,505	\$34,513	\$8
Genomics	\$4,530	\$4,491	\$4,492	\$1
Alzheimer's Disease	\$0	\$1,586	\$1,587	\$0
Inflammatory Bowel Disease	\$0	\$744	\$744	\$0
Interstitial Cystitis	\$0	\$694	\$694	\$0
Pioneering Healthier Communities (YMCA)	\$0	\$1,487	\$1,488	\$0
Total -	\$818,171	\$899,457	\$840,858	(\$58,599)

NARRATIVE JUSTIFICATIONS
HEALTH PROMOTION
CHRONIC DISEASE PREVENTION, HEALTH PROMOTION, AND GENOMICS

Consolidated Grant Categories Budget by Functional Activity (Dollars in Thousands)	FY 2004 Actual	FY 2005 Enacted	FY 2006 Estimate	FY 2006 +/- FY 2005
Heart Disease and Stroke	\$41,628	\$44,618	\$44,627	\$10
Diabetes Prevention and Control	\$59,957	\$63,457	\$63,471	\$14
Cancer Prevention and Control	\$293,825	\$309,705	\$309,778	\$73
Tobacco	\$90,239	\$104,345	\$104,370	\$25
Health Promotion	\$177,025	\$185,501	\$185,543	\$43
School Health	\$57,232	\$56,746	\$56,759	\$13
Prevention Research Centers	\$24,944	\$29,690	\$29,697	\$7
Youth Media Campaign	\$32,060	\$58,795	\$0	(\$58,794)
Steps to a Healthier U.S.	\$41,261	\$46,601	\$46,612	\$11
Total -	\$818,171	\$899,457	\$840,858	(\$58,599)

BIRTH DEFECTS, DEVELOPMENTAL DISABILITIES, DISABILITY AND HEALTH

AUTHORIZING LEGISLATION

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

Birth Defects, Developmental Disabilities, Disability and Health (Dollars in Thousands)	FY 2004 Actual	FY 2005 Enacted	FY 2006 Estimate	FY 2006 +/- FY 2005
BA	\$113,896	\$124,576	\$123,563	(\$1,013)

STATEMENT OF THE BUDGET

The FY 2006 budget request of \$123,563,000 for Birth Defects, Developmental Disabilities, Disability and Health represents a decrease of \$1,013,000 below the FY 2005 Enacted level of \$124,576,000.

PROGRAM DESCRIPTION

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

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

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

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

Funding for Birth Defects, Developmental Disabilities, Disability and Health for the last five years:

FY	FUNDING*
2001	\$70,726,000
2002	\$89,946,000
2003	\$98,039,000
2004	\$113,896,000
2005	\$124,576,000

*FY 2004 and FY 2005 funding levels reflect the removal of management and administrative costs under the new budget structure. FY 2001-2003 funding levels are not available in the new structure and include management and administrative costs.

PERFORMANCE ANALYSIS

GOAL: PREVENT BIRTH DEFECTS AND DEVELOPMENTAL DISABILITIES.

CDC promotes the health of babies, children, and adults; and promotes full, productive living by: 1) monitoring birth defects and developmental disabilities to track rates and identify high risk populations, 2) conducting applied epidemiological research to identify causes of these conditions, 3) developing evidence-based prevention and intervention programs, and 4) educating the public about birth defects and developmental disabilities.

BIRTH DEFECTS

Current Activities

Monitoring birth defects: CDC funds birth defects monitoring and surveillance in 35 states and supports collaboration among states through the National Birth Defect Prevention Network.

National Birth Defects Prevention Study: An ongoing collaborative study of the causes of 30 major birth defects through the Centers for Birth Defects Research and Prevention, funded by CDC.

- Metropolitan Atlanta Congenital Defects Program (MACDP): CDC conducts a model birth defects monitoring program in the Metropolitan Atlanta area to collect, analyze, and interpret birth defects data. The program covers approximately 50,000 annual births from a population of about 2.9 million and serves as a model for many state-based programs and as a resource for the development of uniform methods and approaches to birth defect surveillance. MACDP will be expanded in 2005 to conduct surveillance of all stillbirths to provide the capacity to examine causes of fetal deaths.
- Folic acid educational campaign: CDC provides educational materials to programs in states, managed care organizations and community-based organizations designed to increase consumption of folic acid to prevent spina bifida and anencephaly. CDC data have shown that Hispanic women are more likely to have a pregnancy affected by these neural tube defects. CDC is continuing a targeted campaign to reach Hispanic women with the folic acid message. If preliminary successful results bear out, CDC will work to increase the reach of the campaign to the top U.S. Hispanic media markets.
- Fetal Alcohol Syndrome (FAS): CDC funds programs designed to build statewide capacity in FAS prevention and monitoring; a collaborative research consortium for identifying, developing, and evaluating effective strategies for intervening with children and/or adolescents with FAS and related conditions; research programs to identify and test new FAS prevention and management methods; and education materials for parents, educators and social service providers about accessing appropriate diagnostic and treatment services for affected children and their families.

Significant Accomplishments

- CDC hosted a biologics summit in 2004 to convene experts on optimal use of collected specimens. Through the National Birth Defects Prevention Study, 18,000 maternal interviews have been conducted and over 7,500 infant DNA samples collected. CDC has also disseminated findings from the NBDPS in the form of 50 abstracts accepted to national scientific meetings, nine manuscripts published or in-press, and four manuscripts currently under review. In addition, the Centers have developed increased epidemiologic research capacity, and have published over 100 manuscripts on local research projects supported in part by the CDC cooperative agreement.
- CDC developed an electronic based system that significantly improves the Metropolitan Atlanta Congenital Defects Program's ability to provide timely data for analyses. The database will be ready for use in early 2005.
- CDC recently published a report documenting little change over the past 10 years in the percentage of pregnant women who drink. This report also provided, for the first time, rates of drinking among women who might become pregnant, furthering our understanding of women at risk for an alcohol-exposed pregnancy. Such information is critical to effectively identifying and intervening with women at risk and thus addressing the persistent health challenge of drinking during pregnancy. A CDC-funded competency-based curriculum on fetal alcohol syndrome (FAS) for use by medical and allied health professionals was also recently completed. This curriculum, being implemented at 5 CDC-funded regional FAS centers, is an important tool for educating health care professionals about their role in identifying and intervening with women at risk for an alcohol-exposed pregnancy.

- CDC recently published data documenting the effectiveness of folic acid fortification in preventing spina bifida and anencephaly, severe birth defects of the brain and spine. Data from birth defects monitoring programs showed that, as a result of fortification, approximately 1,000 more babies are born without these birth defects each year.

DEVELOPMENTAL DISABILITIES

Current Activities

- Monitoring and Research: CDC provides funding for 18 states to monitor autism and other developmental disabilities. Seven states are also involved in conducting research on the causes of autism and developmental disabilities.
- Awareness: CDC and its partners are launching “Learn the Signs. Act Early,” a campaign to promote early identification and intervention for children with autism and other developmental disabilities.

Significant Accomplishments

- In January 2003, CDC published the first population-based rates of autism from a major metropolitan area (Atlanta), using data from its Metropolitan Atlanta Developmental Disabilities Surveillance Program. At 3.4 per 1,000, the rates of autism were significantly higher than rates in studies conducted earlier in the U.S., but consistent with more recent studies conducted in other countries. CDC staff are almost finished analyzing data for the next data point, which will be published in 2005 and will include an analysis of any differences from the rates published in 2003. These data will be an important source of information on autism trends. In addition, CDC continues to support the network of autism monitoring programs in other parts of the country – including CDC’s program, a total of 18 states are now tracking rates of autism and other developmental disabilities in children.
- CDC’s autism and developmental disabilities research activities are also moving forward. CDC and its grantees have developed a protocol for a case-control study on the causes and risk factors for autism. When implemented, this study will involve research centers from around the nation and will provide important information on potential causes and risk factors for autism and other developmental disabilities.
- CDC and its partners are initiating the first phase of the CDC-funded “Learn the Signs. Act Early.” Campaign. The purpose of the campaign is to teach parents how to recognize the early warning signs of a developmental disorder and to convince both parents and providers of the importance of acting early.

GOAL: IMPROVE THE HEALTH AND QUALITY OF LIFE OF AMERICANS WITH DISABILITIES.

CDC promotes the health of people living with disabilities. Primary activities include identifying health conditions for which people with disabilities are at increased risk. CDC works to assure that all infants are screened for hearing loss by one month of age, receive an audiologic evaluation by three months, and are enrolled in an intervention program by six months of age if a hearing loss is detected. CDC provides national leadership on collecting accurate data on the prevalence of muscular dystrophy and on identifying risk factors for secondary complications. In addition, CDC works to prevent and reduce complications experienced by people with certain bleeding and blood disorders including hemophilia, von Willebrand Disease, thrombophilia, and thalassemia. Primary goals include: 1) enhance blood safety to prevent the transmission of infectious diseases to persons being treated with blood products; 2) identify risk factors through evidence-based research and surveillance and implement interventions to prevent complications of hereditary blood disorders; 3) prevent and reduce complications of bleeding and clotting disorders that specifically affect women’s health; and 4) develop and deliver consistent prevention education messages to encourage affected persons to make informed decisions about their own health care.

DISABILITY AND HEALTH

Current Activities

- CDC funds research grants to identify promising approaches to promoting health and wellness, and preventing secondary conditions among people with disabilities.
- CDC finances cooperative agreements with state health departments to build capacity in addressing the public health needs of people with disabilities.
- CDC supports the Special Olympics Healthy Athletes Initiative to address the health challenges and disparities encountered by Special Olympics athletes as well as other people with mental retardation.

NARRATIVE JUSTIFICATIONS
HEALTH PROMOTION
BIRTH DEFECTS, DEVELOPMENTAL DISABILITIES, DISABILITY AND HEALTH

- CDC funds three information centers: the National Limb Loss Information Center, the National Information Center on Physical Activity and Disability (NCPAD), and the Christopher and Dana Reeve Paralysis Resource Center.
- CDC finances health promotion initiatives for people with spina bifida through the National Spina Bifida Program.

Significant Accomplishments

- In collaboration with the U.S. Department of Health and Human Services Office on Disability, staff from the CDC Human Development and Disability program has worked to develop *The Surgeon General's Call to Action To Improve the Health and Wellness of Individuals with Disabilities*. The purpose of the Call to Action is to change public perception about disability and identify strategies to improve the health and well-being of people with disabilities living in the United States. Publication of the report is expected in 2005.
- CDC is developing a campaign to convince women with physical disabilities that they should get an annual mammogram and to elevate the importance of breast cancer screening on their list of priorities. Draft concepts and messages were created and tested in Chicago, Illinois, New York, New York, and Salinas, California. Campaign materials are being developed and will be pilot tested in two communities in the spring of 2005.
- In May 2004, CDC published "Vision Impairment and Hearing Loss Among Community Dwelling Older Americans" in the *American Journal of Public Health*. The publication addressed functioning of older people with sensory impairment. As a result of this publication, FDA contacted CDC and requested guidance in meeting its mandate to create recommendations to make over-the-counter medications more accessible to people with vision impairments. A report to Congress will be released citing CDC's work in this area, specifically related to over-the-counter and prescription drugs.

EARLY HEARING DETECTION AND INTERVENTION

Current Activities

- CDC supports 32 states and territories in their efforts to develop surveillance and tracking systems to ensure all newborns are screened for hearing loss and that, when necessary, infants receive appropriate follow up testing and services.
- CDC funds 12 research projects investigating a wide range of topics such as the causes of hearing loss, family interactions, quality of life, and service provision. The results of these studies will provide essential data needed to help make informed policy decisions.

Significant Accomplishments

- In May 2004, CDC assisted in making a Healthy People 2010 Objective on hearing loss measurable. This change will facilitate collection of critical data on the screening, evaluation, and intervention of children with hearing loss. In addition, CDC will assess trends and its own performance in this area more accurately.
- In July 2004, the CDC awarded a Congressional Directed Source to the Marion Downs Hearing Center in Colorado to establish infrastructure and capacity in expanding state, national and international efforts to provide services, resources, education and research supporting the needs of individuals who are deaf and hearing-impaired, their families and professionals.
- In July 2004, the American Academy of Pediatrics through a CDC cooperative agreement launched a web-based Continuing Medical Education module on Childhood Hearing. This module, designed for practicing pediatricians and other health professionals, focuses on the early identification of hearing loss, and promotes the integration of developmental screening and public health screening into the medical home.

DUCHENNE AND BECKER MUSCULAR DYSTROPHY (DBMD)

Current Activities

- CDC funds four states to conduct surveillance and research on the epidemiology of DBMD to determine the incidence of DBMD in the United States and to identify preventable risk factors for secondary complications. CDC also funds an independent quality assurance system for the surveillance program.
- CDC funds two research projects to identify the health care and related service needs of people with DBMD and their families, and the barriers they face in obtaining care.

- CDC funds a research project to assess the knowledge, beliefs and behaviors of female carriers of DBMD regarding preventive cardiac health care.
- CDC funds two research projects to study the feasibility, risks and benefits of newborn and infant screening of DBMD.

Significant Accomplishments

- In April 2004, the surveillance system for DBMD was implemented in four states to determine the incidence in the United States and to identify preventable risk factors for secondary complications.

CHILD DEVELOPMENT STUDIES

Current Activities

- Attention-deficit/hyperactivity disorder (ADHD): Working with a national advocacy organization, Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD), CDC supports the National Resource Center on AD/HD. A three-site, community-based research study was also initiated and is on-going, which will result in estimates of the prevalence of ADHD and treatment, rate of commonly co-occurring disorders, and health status and health risk behaviors in children with ADHD.
- *Legacy for Children*[™]: On-going research program to decrease developmental delays or problems in children at-risk for poor developmental outcomes. This set of long-term, randomized studies examines the potential for improving child health and well-being through programs designed to influence parenting behavior. *Legacy for Children*[™] works with low-income mothers and focuses on increasing their beliefs that they can have a positive impact on their child's development; using parent groups to facilitate positive parenting behaviors; and increasing the amount of time and energy these women invest in their child's development. The study is fully enrolled and on-going in the Miami, FL and Los Angeles, CA metropolitan areas.
- Tourette Syndrome: CDC has established a partnership with the Tourette Syndrome Association (TSA) in support of a Tourette Syndrome Education and Outreach to Service Providers. Through this cooperative agreement, CDC has been working with TSA to bolster provider education and intensive training for healthcare professionals on how to identify, diagnosis, and treat Tourette Syndrome. To further understand the prevalence, risk factors, and comorbidities of TSA, CDC in collaboration with investigators from the University of Oklahoma Health Sciences Center has initiated a pilot epidemiology study of Tourette Syndrome and tics in school-age children. Results from this pilot study are expected by late 2006. Additionally, CDC is supporting extramural research that will identify factors contributing to the quality of life of persons with Tourette Syndrome.
- Developmental Screening: CDC is planning for a developmental screening pilot project to develop and evaluate a viable model for improving developmental screening practices for young children that will lead to an increase in the early identification and appropriate referrals of children at risk for or with developmental delays or disabilities.

Significant Accomplishments

- In May 2003, the research from a nationally representative study documenting a four-fold increased risk of ADHD among the children of mothers reporting a serious mental health condition was published.

HEREDITARY BLOOD DISORDERS

Current Activities

- CDC maintains the Universal Data Collection system (UDC) to monitor blood safety and conduct research on health-care outcomes for persons with bleeding disorders.
- CDC collaborates with health care providers, academic centers, community-based organizations, and national and international preventive health agencies to implement prevention, intervention and education programs, many of which result from CDC-based studies, to persons affected by bleeding, clotting and hereditary blood disorders.
- CDC supports healthcare intervention programs across the U.S. at 134 Hemophilia Treatment Centers (HTCs), 6 Thalassemia Treatment Centers (TTCs), and 8 Hemostasis and Thrombosis pilot sites.
- CDC performs epidemiology and laboratory research to develop new prevention techniques to lessen the impact of bleeding and clotting disorders as well as other inherited blood cell diseases.

Significant Accomplishments

- In 2004, analysis of the UDC data showed no evidence of new hepatitis A, B, C or HIV infections due to the administration of blood products among people with bleeding disorders. A special study conducted among very young patients with hemophilia found that Parvovirus B19 continues to be transmitted by products made from donated plasma and provided evidence that this infection may result in early joint range of motion loss. This study also established that there is no evidence of transmission of West Nile virus through blood products to patients with hemophilia.
- In 2004, CDC published the findings from a comprehensive analysis of measurements on joints collected as part of the UDC demonstrating that excess body weight contributes substantially to joint motion loss among 2-19 year-old boys with hemophilia. This is an especially important finding since the prevalence of overweight in this population is nearly twice that of the general population.
- In 2004, CDC published the results of research characterizing bleeding disorders among women. Findings showed that as many as 2 million women in the U.S. may have von Willebrand Disease (vWD); determined that 15-20% of women with menorrhagia may have a bleeding disorder; and found a gap of 16 years between the onset of symptoms and diagnosis of a bleeding disorder. CDC initiated an awareness campaign for physicians and other health care professionals on bleeding disorders in women and has initiated research to improve diagnosis of bleeding disorders.
- In collaboration with the National Hemophilia Foundation, CDC assisted in the development of a nation-wide "Do the Five" health campaign to encourage individuals with bleeding disorders to adopt 5 key health positive behaviors including getting regular physical exercise, hepatitis A & B vaccination, early and adequate treatment of bleeding episodes, routine monitoring for blood-borne infections, and having a regular checkup with an HTC. Previously published reports have demonstrated that the coordinated care provided by HTCs is known to reduce both mortality and hospitalizations by 40%.

RATIONALE FOR THE BUDGET

The FY 2006 budget request of \$123,563,000 for Birth Defects, Developmental Disabilities, Disability and Health represents a decrease of \$1,013,000 below the FY 2005 Enacted level of \$124,576,000. This includes the restoration of an FY 2005 Labor/HHS/Education reduction of \$62,000.

IT REDUCTION

Funding for the Birth Defects, Developmental Disabilities, Disability and Health activity includes an information technology savings of \$1,075,000.

OUTPUT TABLE

OUTPUT TABLE	FY 2004 ACTUAL	FY 2005 APPROPRIATION	FY 2006 ESTIMATE	FY 2006 +/- FY 2005
Prevent Birth Defects and Developmental Disabilities				
Programs funded for birth defects surveillance and prevention research	37	35	35	0
CDC projects to develop, test, and distribute educational messages for the folic acid campaign	4	4	4	0
FAS prevention state capacity programs	4	7	7	0
Programs to develop effective interventions with children with FAS	5	5	5	0
Research programs for the prevention of Fetal Alcohol Syndrome funded	13	8	8	0
FAS Awareness and Education projects	7	6	6	0
Number of states participating in research on Autism and Other Developmental Disabilities	7	7	7	0

NARRATIVE JUSTIFICATIONS
HEALTH PROMOTION
BIRTH DEFECTS, DEVELOPMENTAL DISABILITIES, DISABILITY AND HEALTH

OUTPUT TABLE	FY 2004 ACTUAL	FY 2005 APPROPRIATION	FY 2006 ESTIMATE	FY 2006 +/- FY 2005
Number of states conducting monitoring for autism and other developmental disabilities	18	18	18	0
Improve the Health and Quality of Life of Americans with Disabilities				
Disability Research Grants	13	7	7	0
Disability State Capacity Grants	16	16	16	0
Disability and Health Information Centers	2	3	3	0
National Spina Bifida Program Research projects	3	4	4	0
State tracking program for Early Hearing Detection and Intervention	32	32	32	0
Research projects for Early Hearing Detection and Intervention	11	12	12	0
States conducting surveillance for DBMD	6	4	4	0
State Research projects for DBMD	5	5	5	0
Attention Deficit Hyperactivity Disorder projects (includes resource center)	4	4	4	0
Hemophilia/Thalassemia Treatment Centers	140	140	140	0
Hemostasis/Thrombosis Pilot Sites	8	8	8	0
Percentage of persons with hemophilia being seen at a HTC who also participate in CDC's Universal Data Collection (UDC) blood safety monitoring program.	85%	87%	87%	0

FUNCTIONAL TABLE

Birth Defects, Developmental Disabilities, Disability & Health Budget by Functional Activity (Dollars in Thousands)	FY 2004 Actual	FY 2005 Enacted	FY 2006 Estimate	FY 2006 +/- FY 2005
Birth Defects & Developmental Disabilities	\$49,416	\$54,112	\$53,672	(\$440)
Human Development and Disability	\$44,730	\$50,239	\$49,830	(\$408)
Hereditary Blood Disorders	\$19,750	\$20,226	\$20,061	(\$164)
Total -	\$113,896	\$124,576	\$123,563	(\$1,013)

HEALTH INFORMATION AND SERVICE

Health Information and Service (Dollars in Thousands)	FY 2004 Actual	FY 2005 Enacted	FY 2006 Estimate	FY 2006 +/- FY 2005
BA	\$95,247	\$94,438	\$89,564	(\$4,874)
PHS Evaluation Transfers	\$115,269	\$134,235	\$134,235	\$0
Total	\$210,516	\$228,673	\$223,799	(\$4,874)
FTE	632	611	611	0

INTRODUCTION

The Health Information and Service Budget activity is responsible for assuring that CDC provides the highest-quality information, programs, and services in the most effective ways to help people, families, and communities protect their health and safety. Through continuous consumer input, prevention-related research, and public health information technology, CDC identifies and evaluates health needs and interests, translates science into actions to meet those needs, and engages the public, health professionals, businesses, and other sectors in improving the health of the nation. In our outreach to partners, CDC builds relationships that incorporate shared learning, mutual trust, and diversity in points of view and sectors of society.

For the first time in CDC's history this unique set of functions and activities has been combined to help the agency reach out more effectively to the public and improve health impact. This is done through three major activities: Health Statistic, Public Health Informatics, and Health Marketing.

CDC places health information at the center of public health through a comprehensive effort to compile statistics on the nation's health. CDC monitors the health status and behaviors of the American public through highly respected data systems such as the National Health Interview Survey and the National Vital Statistics System. CDC also monitors the health care system and, through the National Health and Nutrition Examination Survey, develops and monitors biomarkers for health. These health indicators are especially valuable for identifying health disparities and informing efforts to eliminate those disparities.

CDC applies the power of information and computer science and technology to reach out to the American people and help inform their health decisions. An ongoing, pressing challenge in these uncertain times is responding to possible bioterrorism or other emergency events. The modern discipline of informatics greatly improves our ability in such instances to respond right away with the right information, bridging urgent health needs with timely health data. One exciting opportunity is the development of early detection systems like BioSense which will help us monitor public health in times of crisis.

CDC is exploring new ways to communicate health messages, such as through individualized Web sites, electronic health newsletters, improved formats and channels of delivery for scientific publications, and stronger ties to consumer magazines and entertainment programs. A special focus is the expansion and strengthening of CDC partnerships with sectors that have special reach and influence with the public. A primary sector is the public health community, with efforts aimed at expanding the involvement of state and local health systems in helping achieve CDC's goals, and at improving laboratory systems to more rapidly identify and reduce the spread of potential public health threats. Other key sectors include other Federal agencies, the health care system, educational institutions, and businesses and workers. CDC currently possesses and will continue to develop strong research expertise in areas ranging from consumer research, which identifies the wants, needs, and concerns of the American public, to systematic research reviews which identify effective approaches to preventing disease and promoting health, to economics, social science, public administration, and other relevant disciplines.

HEALTH STATISTICS

AUTHORIZING LEGISLATION

PHSA §§ 301, 304, 306, 307, 308; 1% Evaluation: PHSA § 241 (non-add), (Superceded in the FY 2002 Labor HHS Appropriations Act – Section 206).

Health Statistics (Dollars in Thousands)	FY 2004 Actual	FY 2005 Enacted	FY 2006 Estimate	FY 2006 +/- FY 2005
BA	\$0	\$0	\$0	\$0
PHS Evaluation Transfers	\$90,055	\$109,021	\$109,021	\$0
Total	\$90,055	\$109,021	\$109,021	\$0

STATEMENT OF THE BUDGET

The FY 2006 budget request of \$109,021,000 for Health Statistics represents level funding with the FY 2005 Enacted level of \$109,021,000.

PROGRAM DESCRIPTION

CDC conducts a variety of programs designed to obtain and use health statistics to support decision-making and research on health. CDC's performance goal is to monitor trends in the nation's health through timely, high-quality data systems addressing issues relevant to the nation's health decision makers.

CDC's health statistics provide critical information on where we stand as a society in various areas of health. Statistics inform the public about current public health challenges and provide a foundation for understanding existing health problems. Health statistics are used to recognize emerging trends (e.g. obesity), to create a basis for comparisons between population groups or geographic areas, to identify health disparities and target action and to understand how trends in health change and develop over time.

Health statistics guide national policy and support public programs and goals. Current health information is needed in all sectors of society as a prerequisite for linking risk behavior to health outcomes, targeting health messages and for planning and evaluation of programs that can lead to improvements in health and quality of life.

Statistics make government accountable. Health statistics are used to monitor our effectiveness in addressing public health concerns. These data are used to formulate strategic plans, monitor performance and monitor progress on national goals.

As integrated, multi-purpose mechanisms, health statistics systems are consistent with the "HHS Performance Budget Summary" management initiatives to develop efficient cross-agency approaches to core HHS needs. CDC's health statistics surveys serve the needs of a broad range of programs, researchers and policy makers in CDC, HHS, and across the health community. They are based on sound statistical methods and are conducted in an open, independent and objective manner. Maintaining and building on HHS' existing data systems are important from a management standpoint, as these systems are more efficient than launching multiple independent systems to meet individual agency information needs.

Investments in CDC health statistics systems are critical to advancing our ability to measure health and guide health improvement. In a period of rapid change in health and welfare policy, medical practice, and biomedical knowledge, it is important to make the investments necessary to monitor trends so that we can assess the impact of these changes and guide future policy.

Funding for Health Statistics for the last five years:

FY	FUNDING*
2001	\$121,950,000
2002	\$126,750,000
2003	\$125,899,000
2004	\$90,055,000
2005	\$109,021,000

*FY 2004 and FY 2005 funding levels reflect the removal of management and administrative costs under the new budget structure. FY 2001-2003 funding levels are not available in the new structure and include management and administrative costs.

PERFORMANCE ANALYSIS

CDC's overall goal is to monitor trends in the nation's health through high-quality data systems and deliver timely data to the nation's health decision-makers. In addition, CDC tracks goals for each of the following surveys.

NATIONAL HEALTH AND NUTRITION EXAMINATION SURVEY (NHANES)

This survey is the only national source of objectively measured health data capable of providing accurate estimates of both diagnosed and undiagnosed medical conditions in the population. Through physical examinations, clinical and laboratory tests, and interviews, NHANES assesses the health status of a representative sample of U.S. adults and children. Mobile Examination Centers travel throughout the country to collect data on chronic conditions, nutritional status, behavioral risk factors, dental health, vision and other factors that cannot be assessed by use of interviews alone. Findings from this survey are essential to determine rates of major diseases and health conditions, and constitute a significant resource for monitoring healthcare use, as well as the impact and development of public health policies and interventions.

GOALS

- Use state of the art measurement approaches to gather data that can only be obtained by direct observation, personal interviews and testing of people.
- Provide data for researchers, public health and health policy decision-makers related to diseases, health risk factors, genetics and health, diet and nutritional health status, oral health, environmental exposures, obesity and physical fitness.
- Collect and provide objective data for a joint HHS/USDA effort to monitor the diet and nutrition status of Americans, needed for decisions on food policy, food fortification and dietary guidelines.
- Integrate, and therefore make more effective, the government's approach to collecting information on human health status and environmental exposure.

Current Activities

- Collect information annually on health status obtained through personal interviews with standardized physical and dental examinations, diagnostic procedures and lab tests.
- Maintain continuous field operations on a nationally representative sample of 5,000 individuals at 15 U.S. sites, a continuing logistical and scientific challenge in a time when the public is increasingly resistant to participating in surveys.
- Address priority population groups and issues through efforts to over sample African-Americans, Mexican-Americans, adolescents, persons over 60 years of age, pregnant women and low-income whites.
- Collaborate with other Federal agencies to address specific research and program-driven needs on areas such as oral health, body composition, food activity, lower extremity disease, mental health, vision, diabetes, diet and nutrition, and balance these program-specific needs with broad health topics of continuing importance.
- Serve as the data collection mechanism to monitor diet and nutritional status of Americans by providing information needed for food policy and dietary guidelines.
- Release data findings on a regular basis addressing topics such as cholesterol, growth charts for pediatricians, osteoporosis, environmental smoke, obesity, changes in food/diet, and immunizations.

Significant Accomplishments

- "What We Eat in America, NHANES 2001-2002," a public use data file recently released, contains dietary intake data jointly released by CDC and the U.S. Department of Agriculture's (USDA) Agricultural Research Service. Calculated "4-year" sample weights were also published to merge NHANES 1999-2000 data with NHANES 2001-2002 data.
- Data such as overweight prevalence and increased calorie consumption document the country's epidemic of overweight and obesity and are used to illustrate that the percentage of Americans at elevated risk of a variety of health problems. The Surgeon General used these data and issued a "call to action" which takes the next step and outlines actions that schools, communities, and the industry can take to combat the problem. The data has resulted in the Secretary and CDC Director bringing public attention to the obesity problem and discussing positive steps for the public to take with exercise and making better choices in the foods we eat. The data has led to legislative initiatives and changes in messages and food choices from the fast food industry.
- Data provide answers for researchers and nutritionists, and are used as the basis for recommendations on food fortification decisions, on the recommended amount of vitamins and minerals essential for a healthy diet (i.e., iron for women of childbearing age, preschool children and the elderly).
- Data have guided the national policy regarding folic acid fortification to prevent neural tube defects. Data helped to define a problem and set policy to address it, and now are being used to monitor the impact of that policy. Data on two neural tube defects, spina bifida and anencephaly, show declines in the rates. The rate of spina bifida in 2002 was 20.13 per 100,000 live births, a decrease from 22.84 in 1992. The rate of anencephaly in 2002 was 9.55 per 100,000 live births, significantly lower than the rate in 1997 at 12.51 per 100,000 live births.
- Expanded exposure monitoring activities to assess the exposure of the U.S. population to 116 environmental chemicals, published in the *2002 Second National Report on Human Exposure to Environmental Chemicals*. NHANES data are used to determine reference (or normal) ranges of exposure to these chemicals and to monitor which environmental chemicals Americans are exposed to, how much of a chemical we're exposed to, and trends in exposure over time.

NATIONAL VITAL STATISTICS SYSTEM (NVSS)

The NVSS program provides the nation's official vital statistics data based on the collection and registration of birth and death events at the state and local level. The NVSS provides the most complete and continuous data available to public health officials at the national, state and local levels and in the private sector.

GOALS

- Provide data to monitor progress toward achieving health and welfare reform goals (i.e., number of teen births, out-of-wedlock birth data, prenatal care, infant mortality data, leading causes of death, life expectancy).
- Support research and decision-making by providing high quality timely data to health officials on key national health indicators at the national, state and local level.
- Work with partners in states and Federal agencies to continue to build a re-engineered, web-based vital statistics system that involves the initial recording of birth and death certificates via electronic systems in hospitals and funeral homes for rapid release of data for decision-making.
- Implement new national model certificates of birth, death and fetal death events to improve data quality and update the content of these data sources to reflect needs on changing classification of race/ethnicity and emerging concerns in maternal and infant health and public health.

Current Activities

- Continue to work with states on the implementation of a web-based system for collection of statistics including implementation of content revisions of the U.S. Standard Certificates of Live Birth, Death and Fetal Death.
- Assist states in the development of systems specifications for their new registration systems based on the use case models developed by Social Security Administration (SSA), NAPHSIS (National Association for Public Health Statistics and Information Systems) and CDC.

- Continue to provide data to monitor key national indicators, including reductions in teen pregnancies, low birth weight and preterm birth, and maternal risk factors including smoking during pregnancy, hypertension, and anemia.
- Provide state-level data used for the welfare reform performance objective of reducing out-of-wedlock births.

Significant Accomplishments

- Data from the National Survey of Family Growth which showed that sexual activity declined significantly for younger teenage girls and for teenage boys between 1995 and 2002. The *Washington Post* reported that "Researchers praise the periodic survey as one of the most authoritative sources of information on adolescents, in part because it reaches teenagers in and out of school and because it measures not only attitudes but also specific behaviors."
- Data for 2002 show the birth rate among teens dropped to a record low of 43.0 births per 1,000 females aged 15-19 years, a decrease of five percent from 2001. Birth rates for women aged 35-39 and 40-44 years increased to their highest levels in more than three decades – to 41.4 and 8.3, respectively. Birth rates for unmarried women changed very little from 2001. Tracking these vital statistics is critical to national policy on teen pregnancy prevention and initiatives to reduce out-of-wedlock births.
- Data for 2002 show life expectancy in the U.S. was the highest ever at 77.4 years. It also shows the first rise in the infant mortality rate in more than four decades. Early provisional data for 2003 suggest a return to the downward trend. These data are crucial for public health officials at the national, state and local level to monitor progress toward achieving health goals.
- Developed a consensus national documentation of best practices for how electronic birth and death certificate systems will operate in partnership with SSA and NAPHSIS. This documentation includes technical standards and specifications that will enable rapid progress in the development and implementation of software that can greatly accelerate timeliness and quality of vital statistics. Phase 1 requirements for the model vital statistics system are complete and now publicly available. The State of Georgia is in the process of developing a new electronic birth system based on these requirements, and New York City also is developing a re-engineered death registration system based on the model requirements.

NATIONAL HEALTH INTERVIEW SURVEY (NHIS)

The program provides information annually on the health status of the U.S. civilian non-institutionalized population through confidential interviews conducted in households. The NHIS has the size and breadth of content to provide critical information on population subgroups and to relate health status to behaviors, access to care, and insurance. Health agencies and organizations use the data to plan and monitor health policies and programs.

GOALS

- Provide data for analysis of broad health trends, as well as data to characterize persons with various health problems, determine barriers to care, compare health status, health-related behaviors and risk factors across racial and ethnic populations.
- Provide rapid data on a quarterly basis on current health issues such as health insurance and immunizations for health policy makers.
- Improve overall timeliness and quality of the survey data through re-engineering of the system and redesign of the sample to positively affect all aspects of the survey including data collection, post production, timely dissemination and usability of health statistics.

Current Activities

- Publishing data on a quarterly basis on lack of health insurance coverage to reflect different policy-relevant perspectives on persons with access to care, such as a regular source of care. The data provides three fundamental measures of health insurance coverage at the time of interview: 1) persons who currently lack coverage; 2) the estimate of persons who were uninsured at any time in the past year; and 3) the measure of lack of coverage for more than one year. These measures are released six months after collection.
- In addition to the health insurance data, collecting and publishing data on a quarterly basis on health status and disability, access to care, use of health services, immunizations, health behaviors, ability to perform daily activities and child mental health.

- Designing and implementing a new sample for the NHIS to ensure it accurately reflects the shifting U.S. population demographics identified in the decennial census and refocus surveys on population groups that are growing.

Significant Accomplishments

- Successfully completed development and implementation of new technology for collecting and processing the NHIS, using state-of-the-art computer assisted survey interview methods and automated systems for processing data into analytic form, enabling the program to meet the goal of data release six months after data collection.
- Collaborated with the National Institutes of Health and published the *Complementary and Alternative Medicine (CAM) Use Among Adults*. The survey included questions on 27 types of CAM therapies commonly used in the U.S., including 10 types of provider-based therapies, and 17 other therapies that do not require a provider.
- Data were published (1997-2003) on trends in health insurance coverage by poverty status among persons under 65 years of age. Data are used by public health officials to gain a more complete understanding of the uninsured population, those with less access to care and those less likely to be receiving preventive services. Data show the annual percent of uninsured persons decreased from 15.4 percent (41 million) in 1997 to 15.1 percent (43.1 million) in 2003. The percent of uninsured children under 18 years old declined from 13.9 percent (9.9 million) in 1997 to 9.8 percent (7.2 million) in 2003. Data are used by policy makers to show the proportion of the population that lack coverage and to understand the shifts in coverage from private to public sources (such as SCHIP and Medicaid).

NATIONAL HEALTH CARE SURVEY (NHCS)

The NHCS program provides a picture of how hospitals, emergency and outpatient departments, ambulatory surgery centers, nursing homes, hospices, and office-based physicians deliver healthcare. It is a rich source of data on healthcare use and characteristics of patients and providers, and provides information on medical technology and the quality of care provided to a changing U.S. population.

GOALS

- Use data to profile changes in the use of health care resources, patterns of disease, and the impact of new medications and technologies.
- Provide information on the characteristics of a broad range of providers, facilities, and patients to allow researchers to study shifts in the delivery of health care across the health care system, variations in treatment patterns and use of services and patient outcomes.
- Provide data to fill important data needs related to HHS priorities including physician reimbursement, how providers respond to financial and non-financial incentives, the capacity of the health care safety net to serve the uninsured, the capacity of emergency departments to respond to bioterrorism, patterns of prescription drug use and health care quality.

Current Activities

- Preparing data for analysis after CDC redesigned and conducted the 2004 National Nursing Home Survey (NNHS). This survey includes an increased sample size, expanded clinical content, new information on staffing and turnover, data on facility policies and practices, and the use of computer-assisted personal interviewing. The NNHS includes the first-ever nationwide survey of nursing assistants.
- Increasing the utility of the National Ambulatory Care Medical Care Survey and the National Hospital Ambulatory Medical Care Survey by increasing the number of participating providers.
- Implementing new methods and technology to better reflect the changing distribution of the population and changes in the mix and range of health care providers, to take advantage of existing record systems and especially electronic systems, to incorporate a wider range of data items such as prescription drugs and clinical quality measures.

Significant Accomplishments

- Data are used to examine prescribing practices for medications that can potentially lead to adverse drug reactions, declines in physical functioning, and excess utilization of health care. Data show patients age 65 and older were prescribed inappropriate medications at almost eight percent of doctor visits in 2000, about

NARRATIVE JUSTIFICATIONS
HEALTH INFORMATION AND SERVICE
HEALTH STATISTICS

the same percent as in 1995. Inappropriate medications were defined as those that had a risk of adverse outcomes outweighing the potential benefits.

- Data are used to show public health officials at the national, state, and local level that the nation's emergency departments form a major part of our nation's health care safety net and are often the provider of last resort. Data show 110.2 million visits to hospital emergency rooms in 2002, an increase of 23 percent over the 90 million visits made in 1992.
- Data are used to examine the effect of changes in reimbursement policy on utilization of long term care services. For example, while the length of home health care use among Medicare discharges decreased after implementation of the Medicare interim payment system, there was no corresponding change among non-Medicare discharges. Data from the *2000 National Home and Hospice Care Survey* detail the latest findings on characteristics of agencies providing home health and hospice care services, their current patients, and discharges. Long-term care is an area of critical policy interest due to the aging population, and the rising cost of entitlement programs for long-term care.

RATIONALE FOR THE BUDGET

The FY 2006 budget request of \$109,021,000 for Health Statistics represents level funding with the FY 2005 Enacted level of \$109,021,000.

OUTPUT TABLE

OUTPUT TABLE	FY 2004 ACTUAL	FY 2005 APPROPRIATION	FY 2006 ESTIMATE	FY 2006 +/- FY 2005
Monitor Trends in the Nations Health through High-quality Data Systems Addressing Issues Relevant to Policy-makers				
Number of key elements of the health care system for which data are collected	3	3	3	0
Number of communities visited by mobile examination centers from the National Health and Nutrition Examination Survey	15	15	15	0
Data systems for which significant efforts will be underway for redesign, reengineering, or transformation	2	3	3	0
Number of households interviewed in the National Health Interview Survey	~40,000	~40,000	~40,000	0
Disseminate Health Data in Innovative Ways				
Improvements in data dissemination via the Internet (# new products developed for Internet per year)	1	1	1	0
Release data on high priority issues in new formats (# new reports per year)	2	2	2	0
Increase number of new users to NCHS Web site	5%	5%	5%	0

FUNCTIONAL TABLE

Health Statistics Budget by Functional Activity (Dollars in Thousands)	FY 2004 Actual	FY 2005 Enacted	FY 2006 Estimate	FY 2006 +/- FY 2005
Field Operations	\$45,269	\$59,833	\$59,833	\$0
Statistical Program Infrastructure	\$44,786	\$49,188	\$49,188	\$0
Total -	\$90,055	\$109,021	\$109,021	\$0

PUBLIC HEALTH INFORMATICS

AUTHORIZING LEGISLATION

PHSA §§ 301, 304, 306, 308, 307, 310, 311, 317, 318, 319, 319A, 319B, 319C, 327, 352, 391, 1102, 2315, 2341
Clinical Laboratory Improvement Amendments of 1988, §4

Public Health Informatics (Dollars in Thousands)	FY 2004 Actual	FY 2005 Enacted	FY 2006 Estimate	FY 2006 +/- FY 2005
BA	\$48,793	\$48,379	\$43,482	(\$4,897)
PHS Evaluation Transfers	\$24,751	\$24,751	\$24,751	\$0
Total	\$73,544	\$73,130	\$68,233	(\$4,897)

STATEMENT OF BUDGET

The FY 2006 budget request of \$68,233,000 for Public Health Informatics represents a decrease of \$4,897,000 below the FY 2005 Enacted level of \$73,130,000.

PROGRAM DESCRIPTION

Information systems and information technology are critical to the practice of public health in the 21st century. Informatics provides new and creative solutions by using information and information systems to address public health problems. In doing so, informatics extends the reach of public health professionals, allowing each of them to achieve more. Public health involves collecting, analyzing, and sharing data that drive evidence-based decisions with the goal of improving health impact. Public Health Informatics supports these functions and provides new capabilities for preventing and managing diseases and other public health threats to support even greater health impact. CDC's FY 2006 budget request includes the new Public Health Informatics activity to enhance discovery, innovation, and application of public health information and information systems so as to support public health and public health preparedness. The new activity will strengthen CDC's leadership role in public health informatics policy and standard setting, in defining informatics needs nationally, and increase capacities for public health informatics research.

The new activity will reflect the work of CDC organizations involved in public health to define the needs for public health information systems, to develop the standards that allow for these systems to work together effectively and when appropriate, develop systems and software that extend the capabilities of public health. The new activity will also elevate informatics as a discipline nationally—making it an area of focus across all of public health, especially at the state and local level. Informatics involves the bridging of health professionals and information technologists. Public health needs informatics to ensure that the best solutions are used to achieve optimal public health outcomes.

Among many responsibilities, CDC's Public Health Informatics activity includes the Public Health Information Network (PHIN), ensuring that necessary public health information systems are present and working together at the state, local and federal levels. Through this activity, CDC will help state and local public health partners develop informatics solutions to better execute programs including the development of systems and standards to ensure that the nation is prepared in the event of a terrorism attack or other public health emergency.

Key priorities in the preparedness aspects of PHIN include BioSense, which focuses on early event detection by connecting electronic health records from hospitals, clinics, and other health-related sources and using them for early-detection purposes, outbreak management, communications and alerting, connecting laboratory systems and countermeasure and response administration.

CDC's Public Health Informatics activity will have cross-cutting capabilities to support a variety of programs. CDC will also conduct and support basic public health research and development, with the goal of creating more advanced and integrated informatics systems to protect and improve the public's health.

Funding for Public Health Informatics for the last five years:

FY	FUNDING*
2001	N/A
2002	N/A
2003	N/A
2004	\$73,544,000
2005	\$73,130,000

*This budget activity has been created as part of CDC's new budget structure; therefore, funding levels are not available for FY 2001 – FY 2003.

PERFORMANCE ANALYSIS

PUBLIC HEALTH INFORMATION NETWORK (PHIN)

The PHIN Initiative seeks to ensure information systems capabilities are in place to support public health across the broad range of public health functions and strives to improve the electronic exchange of health data and information between clinical healthcare and state and local public health partners as well as federal officials through national standards based approaches to information technology and health data. PHIN includes detection and monitoring, data analysis and interpretation, information resources and knowledge management, alerting and communications, and response. PHIN also leverages, integrates and coordinates existing systems and initiatives to help achieve these goals.

As public health preparedness now involves the strategic use of information technology to support a number of critical public health functions, PHIN Preparedness has been created to immediately address system capabilities at the state and local levels. The initial release of PHIN Preparedness systems needs, standards and specifications include systems capability for early event detection, outbreak management, connecting laboratory systems, countermeasure and response administration, and partner communications and alerting. Subsequent iterations will focus on additional public health functions such as routine/traditional surveillance and information dissemination and knowledge management. PHIN Preparedness establishes and links all of these critical areas of public health and strives to identify and address gaps associated with the needs of national public health information capability.

Current Activities

Initial funding for PHIN was received in FY 2004, and CDC is currently advancing the following PHIN objectives:

- Documenting public health requirements at the local, state and federal levels
- Identifying standards from industry, federal and health practices that support these requirements
- Defining specifications based on these standards and requirements
- Building software, services, and application components that implement these specifications for use across multiple functional areas
- Actively certifying systems for functional coverage and core capabilities within the PHIN Preparedness functional areas.

Significant Accomplishments

- Accumulated and refined the requirements and key performance indicators for preparedness systems for the following areas:
 - Early event detection – the identification, quantification and localization of possible bioterrorism and naturally occurring disease outbreaks.
 - Outbreak management – the capture and management of data associated with the investigation and containment of an outbreak or public health emergency.
 - Connecting laboratory systems – enabling laboratories involved in public health testing to electronically exchange laboratory-related information with public health partners.
 - Countermeasure and response administration – the management and tracking of measures taken to contain an outbreak or event, or to provide protection against a possible outbreak or event.

- Partner communications and alerting – the rapid distribution of health alerts and collaborative communications among public health professionals and the broad sharing of information with the public.

These requirements, available on CDC's PHIN website site (www.cdc.gov/phin), have been directed for use at the state and local levels and will be the basis for ensuring that interoperable preparedness systems will be in place to support a wide variety of public health activities.

- Completed a series of 6 regional two-day conferences in 4 months (co-sponsored by the Association of State and Territorial Health Officials (ASTHO) and the National Association for County and City Health Officials (NACCHO) and held in Ft Worth, Portland, Atlanta, Boston, Chicago and Las Vegas) to review the requirements for establishing information systems needs for national preparedness.
- Developed message specifications and implementation guides to support reporting from states and larger urban areas for over 100 notifiable conditions.
- Developed message specifications to support state and local public health officials in covering laboratory reporting from clinical and public health laboratories for human and environmental testing, including bioterrorism.
- Developed messages and standards for use at the state and local levels for vaccination reporting, smallpox vaccination program and active surveillance reporting.
- Developed messages for surveillance and early detection including hospital chief complaint, emergency room diagnosis, and ambulatory care diagnosis and procedures to support state and local public health preparedness and response.
- Widely used PHIN standards to transmit public health information used for event detection and routine surveillance reporting. To date, CDC has sent, received and/or processed numerous records from various sources and improved disease reporting times as indicated below:
 - >100,000 Health Level 7 ("HL7" -- an international standard for the exchange, management, and integration of clinical and administrative data) standard public health lab results from 22 Laboratory Response Network (LRN) facilities.
 - >125 million patient records sent in HL7 format from Department of Defense to public health (BioSense),
>176 million records sent in HL7 format from Veteran's Administration to public health (BioSense).
 - >16,000 HL7 standard, clinical lab notifiable disease results sent to 15 states.
 - Reduction in communicable disease reporting time from approximately 25 days to three days (NEDSS base system).

SURVEILLANCE AND INFORMATICS

Public health surveillance is the systematic, ongoing assessment of the health of a community through routine collection, analysis, and dissemination of information on disease and injury. By using surveillance information and the electronic informatics applications that facilitate the transmission and reporting of this information, public health agencies or communities can set priorities, take appropriate action to prevent illness, and evaluate the effectiveness of their programs.

Current Activities:

- CDC's surveillance and informatics activities include evaluating data and systems to improve efficiency and quality; developing and operating systems for surveillance and information exchange; and building community health assessment, public health surveillance, and informatics capacity through technical assistance, training, and consultation—in support of both the electronic applications and the epidemiological methods and processes that together comprise a surveillance "system". Assistance is provided to international, state, and local health agencies, as well as non-traditional partners like medical examiners.
- A comprehensive surveillance assessment is being conducted for Iraq to evaluate the country's current surveillance status and develop a proposal for a multi-year system development project. Deployment of the electronic surveillance system in both laboratory and clinical environments will be completed in Central Asia and the Republic of Georgia, and epidemiologists in these countries will receive surveillance training.
- Through the National Notifiable Disease Surveillance System (NNDSS), CDC monitors, tracks and publishes information on more than 60 mandated notifiable infectious diseases in the United States, including foodborne illness outbreaks, contaminated water sources, AIDS, hepatitis, and others. The 122 Cities

Mortality Reporting System compiles total mortality counts and counts of pneumonia and influenza mortality by age group from selected cities each week. CDC also provides tools and resources to support public health surveillance practice including Epi Info, a public domain software package designed for the global community of public health practitioners and researchers to assist in data collection, analysis, mapping, and reporting; and Wide-ranging ON-line Data for Epidemiologic Research (WONDER), an easy-to-use Internet system that simplifies access to public health data and information for state and local health departments, other federal programs, and the academic public health community.

- A new tabular and graphical display of NNDSS data in CDC's *Morbidity and Mortality Weekly Report* (MMWR) is being developed for implementation. New epidemiologic studies are being initiated using NNDSS data, and CDC staff is creating an NNDSS (morbidity) Data Mart to serve the needs of multiple CDC programs.
- Through the AI Cooperative Agreement, a special focus issue of the *Journal of Public Health Management and Practice* is being produced, addressing *Interactive Web-based Systems for Analysis, Display, and Dissemination of Population Health Data--Implications for Public Health Practice*. Epi Info is developing a new tutorial targeting community health assessment.
- A business plan is being developed to provide guidance and direction for the future of Epi Info at CDC; requirements gathering will be completed for the next version of Epi Info focusing on stakeholder needs and usefulness in counter bioterrorism initiatives and disaster management. A structured Epi Info training program with train-the-trainer certification, and an Epi Info public health marketing plan, is also being developed and implemented.
- WONDER staff is collaborating with CDC's PHIN to develop a population Data Mart to supply a credible source of denominator data. Improved features requested for statistical and data modeling and analysis and visualization will be developed. Information and data content in WONDER will be enhanced.

Significant Accomplishments

- NNDSS-Link, a web-based tool for display, analysis, and aberration detection associated with infectious disease case and risk factor data, was made available to epidemiologists and disease control program managers throughout CDC.
- An intergovernmental working group between CDC and the Council of State and Territorial Epidemiologists (CSTE) finalized a set of guidelines for CDC programs collecting and re-releasing state surveillance and other public health data. These guidelines will encourage widespread use of important data while providing important protections against inadvertent identification of individuals.
- As a joint effort between the National Association of Medical Examiners (NAME) and CDC, *The Medical Examiners, Coroners, and Biologic Terrorism: A Guidebook for Surveillance and Case Management* was recently released for publication.
- The International Surveillance System Development Project developed and implemented the National Egyptian Disease Surveillance System and a similar system in El Salvador. In FY 2005, a new 5-year project was launched in Central Asia and the Republic of Georgia to develop an electronic surveillance system for detection and monitoring of 14 dangerous pathogens.
- Funding awards were made to 7 participating states and 2 national public health organizations through the CDC Assessment Initiative (AI) and a related cooperative agreement program. In 2004, the National AI Conference drew approximately 300 representatives from federal, state, and local health agencies, public health organizations, universities, and private sector groups to share innovative resources and approaches for community health assessment.
- Epi Info Version 3.3 was recently released and an Epi Info Stakeholder Retreat conducted to obtain vital feedback from end users.
- CDC's WONDER System developed five new data query applications, along with new on-line analysis, visualization, and reporting features. Fourteen years of data were also added to WONDER's public data dissemination web site, and a new mapping feature deployed. Over 310,000 computers are estimated to have downloaded information from WONDER's web server in 2004.

NATIONAL ELECTRONIC DISEASE SURVEILLANCE SYSTEM (NEDSS)

The National Electronic Disease Surveillance System is an initiative that promotes the use of data and information system standards to advance the development of efficient, integrated, and interoperable surveillance systems at federal, state, and local levels. A primary goal of NEDSS is the ongoing, automatic capture and analysis of data that

are already available electronically. NEDSS is the surveillance and monitoring component of PHIN. NEDSS is based on the following principles:

- Utilization of *de facto* industry standards.
- Emphasis on off-the-shelf software, whenever possible and appropriate.
- Internet-based secure transmission of data.
- Common electronic messaging requirements.
- No requirement by states to use specific software, although the CDC implementation of NEDSS (the NEDSS Base System) is available for those states who request it.

CDC has been instrumental in developing a public health conceptual data model and guidelines that recommend a minimum set of demographic data that should be collected as part of routine public health surveillance. As a result of this effort, in FY 2000, CDC created the NEDSS to set up the necessary CDC infrastructure, such as training, hardware, and software for the system, and awarded funds to states to begin development. In FY 2003 and 2004, CDC funded 57 states/major jurisdictions for NEDSS development and implementation activities.

GOAL: DEVELOP A NATIONAL, INTEGRATED, STANDARDS-BASED PUBLIC HEALTH SURVEILLANCE INFRASTRUCTURE THAT IS SECURELY LINKED TO HEALTHCARE PRACTICE.

Disease surveillance and tracking is the foundation of public health practice. With the advent of secure, web-based data transport and near real-time data repositories, the ability to develop integrated and standards-based systems that leverage hardware, software and human IT resources has emerged. These systems significantly impact the capacity for earlier detection, comprehensive data collection, smarter decision-making, more efficient allocation of scarce public health resources, and timely and appropriate public health response.

The NEDSS Base System is a specific implementation of NEDSS which facilitates public health surveillance through the transfer and processing of appropriate public health, laboratory, and clinical data efficiently and securely over the Internet.

Current Activities

- In FY 2004, funding was provided to 57 health jurisdictions, and the NEDSS Base System will be installed in over 30 states and major jurisdictions (the average award was \$300,000 for planning and coordination activities within each state).
- The current version of the NEDSS Base System provides surveillance for over 140 diseases. Version 1.1.3 was released in May 2004 and adds all reportable foodborne and diarrheal diseases, human and animal rabies, lyme disease and customizable field functionality to the system.

Significant Accomplishments

- The NEDSS Base System is currently “live” in ten (10) states: Nebraska, South Carolina, Tennessee, Texas, Alabama, Oregon, Vermont, Nevada, Virginia, and Idaho. CDC staff are actively involved in training and installation of the system in Arkansas, Maryland, New Mexico, Rhode Island, and Maine. Additionally, the following states and major metropolitan areas are evaluating the NEDSS Base System for their use: Wisconsin, Minnesota, Montana, Wyoming, South Dakota, Ohio, New Hampshire, New York City, Houston, and Philadelphia.
- In the pilot state for the NEDSS Base System, Nebraska, significant increases in timeliness and completeness of reporting have been seen.
 - The traditional paper reporting method from a major national laboratory system was shown to receive only 36 percent overall of the actual reports received through electronic reporting via the NEDSS Base System. For example, childhood lead surveillance was only receiving three percent of ALL the reports that should have been sent.
 - The turnaround time for receiving reports decreased from an average 24 day lag to a three day lag.
 - In addition, this information has been seamlessly auto-populated in NEDSS electronic forms, dramatically reducing the clerical work that epidemiologists and other public health support staff previously had to perform, allowing them to focus their expertise on public health response to reported diseases and in preventing future disease transmission.

- Increases in the number, completeness and timeliness of disease reports, a key fundamental in effective public health response, is due in large part to the development of standards-based electronic reporting. This has reduced the burden on CDC's key reporting sources: healthcare providers and laboratories.

INFORMATION, COMMUNICATION, AND KNOWLEDGE MANAGEMENT SYSTEMS

Managing increasing amounts and types of public health information and data and ensuring its timely and intuitive access by partners, citizens and the internal CDC community is a critical necessity to achieve and advance the objectives and goals of public health. To meet these needs, CDC has developed a unified knowledge management approach that has been and is being implemented across the Agency. CDC is also working with its public health partners to build the information and communication infrastructure at the state and local levels. These efforts are aligned with the E-Government Act of 2002 which requires the use of Internet-based information technology to enhance citizen access to government information and services, section 515 of the Treasury and General Government Appropriations Act for Fiscal Year 2001, Public Law 106-554 which focuses on ensuring the quality and integrity of information disseminated by Federal Agencies, and e-Gov's Federal Health Architecture.

Current Activities

- Enterprise content management
 - CDC is working to improve access to and availability of information on its public and secure-partner websites through the systematic application of metadata and taxonomies.
 - CDC is working to improve the Agency-wide management of information and knowledge through a consistent use of an enterprise content management system.
 - CDC is working to better support its approval process of published information through the consistent use of rules-based workflows within the enterprise content management system.
- Enterprise communication platform
 - CDC is working to improve information-based communication with public health partners through the application of standards-based communication protocols and systems.

Significant Accomplishments

- CDC has successfully implemented an enterprise content management system. This system is the repository for both Web and non-Web information.
- Two public health topics have been successfully migrated to the new content management system: Folic Acid and Traumatic Brain Injury.
- CDC has successfully implemented an electronic workflow application based in the content management system designed to support the Agency's scientific clearance process.
- CDC has successfully launched a "public health partner portal" aimed at delivering information and services to a broad range of CDC's partners. A critical service offered to public health partners during the flu vaccine crisis was the "flu vaccine finder" application which allowed local public health officials to track vaccine supplies and distribution in their area.

RATIONALE FOR THE BUDGET

The FY 2006 budget request of \$68,233,000 for Public Health Informatics represents a decrease of \$4,897,000 below the FY 2005 Enacted level of \$73,130,000. The reduction applies to the Public Health Information Network (PHIN), as some portions of PHIN move from standards design activities to system implementation. Additional funding is provided for activities related to PHIN through activities such as NEDSS, Terrorism, and other CDC programs.

OUTPUT TABLE

OUTPUT TABLE	FY 2004 ACTUAL	FY 2005 APPROPRIATION	FY 2006 ESTIMATE	FY 2006+/- FY 2005
National Electronic Disease Surveillance System				
States actively engaged in ongoing NEDSS/PHIN-compatible systems integration	21	45	48	3
States developing NEDSS-compatible systems, in deployment, or live with the NEDSS Base System	36	44	46	2

FUNCTIONAL TABLE

Public Health Informatics Budget by Functional Activity (Dollars in Thousands)	FY 2004 Actual	FY 2005 Enacted	FY 2006 Estimate	FY 2006 +/- FY 2005
PHIN	\$9,911	\$9,827	\$4,912	(\$4,915)
NEDSS	\$24,751	\$24,751	\$24,751	\$0
All Other Public Health Informatics	\$38,882	\$38,552	\$38,570	\$18
Total -	\$73,544	\$73,130	\$68,233	(\$4,897)

HEALTH MARKETING

AUTHORIZING LEGISLATION

PHSA §§ 301, 304, 306, 308, 307, 310, 311, 317, 318, 319, 319A, 319B, 319C, 327, 352, 391, 1102, 2315, 2341
Clinical Laboratory Improvement Amendments of 1988, §4

Health Marketing (Dollars in Thousands)	FY 2004 Actual	FY 2005 Enacted	FY 2006 Estimate	FY 2006 +/- FY 2005
BA	\$46,454	\$46,059	\$46,082	\$23
PHS Evaluation Transfers	\$463	\$463	\$463	\$0
Total	\$46,917	\$46,522	\$46,545	\$23

STATEMENT OF BUDGET

The FY 2006 budget request of \$46,545,000 for Health Marketing represents an increase of \$23,000 over the FY 2005 Enacted level of \$46,522,000.

PROGRAM DESCRIPTION

CDC's Health Marketing activity is included in the FY 2006 budget request to reflect CDC's commitment to its direct link with our customers – the people whose health we can improve. The new activity applies commercial, non-profit, and public service marketing practices to better understand people's health-related needs and preferences; to motivate changes in people and organizations to protect and improve health; and to develop partnerships with public and private organizations to work with CDC in disease prevention and health promotion activities. Health marketing focuses on giving people knowledge that empowers them to make informed personal choices about their health, and on changing the environment in ways that give people the opportunity to act on those choices.

As applied at CDC, health marketing is a:

- **Management function**, connecting all activities within CDC – research, surveillance, program services, policy, communications – strategically.
- **Creative function**, developing and delivering health messages and programs which get people's attention and resonate emotionally to position health as a means of achieving what people really value – such as having energy, staying independent, and meeting friends.
- **Scientific function**, grounded in theory and practice from a number of academic disciplines, operating from an evidence base of effectiveness, and evaluating and improving itself by seeking customer input and feedback rigorously and continuously.

In carrying out these functions, CDC accesses, promotes, and conducts research and analysis on customers, partners, and approaches; develops and evaluates strategies and methods for providing information, programs, and services; develops and tests communication messages and information and service-delivery programs for public and professional audiences; develops and coordinates high-priority partnerships; manages policy and strategy for CDC's brand identity; delivers CDC information and services to the public; and manages marketing-related shared services (e.g., channels, graphics).

As a whole, these activities

- Ensure that CDC obtains and analyzes the necessary data about its customers to develop information, interventions, and programs that respond to customers' needs, values, and uses.
- Ensure that CDC employs innovative and rigorous strategies for reaching its customers based on audience and communication research.
- Provide value-added cross-cutting scientific support that ensures that the best available public health science is rapidly and reliably translated into effective practice and policy.
- Ensure efficient, focused use of CDC's expertise and mechanisms for delivering health information and services.

- Ensure that customers will have effective, real-time access to needed health and safety information, interventions, and programs through communication channels they prefer.
- Ensure effective strategic partnerships and alliances to extend CDC's reach.
- Increase public awareness and partner actions to enhance the public health infrastructure.
- Help people understand what public health is as well as its relevance and value to people across all life stages.
- Promote and facilitate efforts to measure progress toward agency goals and evaluate the impact of agency programs.

Funding for Health Marketing for the last five years:

FY	FUNDING*
2001	N/A
2002	N/A
2003	N/A
2004	\$46,917,000
2005	\$46,522,000

*This budget activity has been created as part of CDC's new budget structure; therefore, funding levels are not available for FY 2001 – FY 2003.

PERFORMANCE ANALYSIS

The goal of the Health Marketing activity is systematically to change health-relevant attitudes, knowledge, and actions of organizations and individuals in order to protect and improve health.

PUBLIC HEALTH PARTNERSHIPS

Achieving CDC's health impact goals requires vigorous and active partnership with state and local health agencies as well as partnerships with organizations representing those agencies. In the past, CDC has not had a systematic agency-wide approach to engage public health in CDC's disease prevention and health promotion goals. Through sector management, the Health Marketing activity is providing a distinct focus on our public health partners, identifying their priorities and developing strategies for efficient and effective working relationships.

Current Activities

- The laboratory systems initiative continues to promote excellence in laboratory practices and service through a quality systems approach and to expand relationships with organizations representing public and private-sector laboratories. Both public health and clinical laboratories provide essential support for public health programs as well as information addressing individual health care needs.
- The state and local health systems initiative continues to work with public health agencies and organizations, and will expand the scope of activities to ensure that CDC partners have high-quality information that will facilitate interactions with these partners and successful joint strategies and activities that address CDC goals.
- Public Health Partnerships is supporting CDC's Public Health Agency Portfolio Management pilot project. The goal of this pilot project is to strengthen CDC's relationship with state and local health agencies through shared leadership, a commitment to common health protection goals, and the effective use of resources. Working with these agencies, CDC is assessing how to improve services to states and exploring the alignment of current CDC-funded programs and leveraging of available resources for the maximum impact on health.
- CDC continues to provide placement, management and high level strategic coordination of CDC's domestic field services and personnel.
- CDC is establishing a systematic approach that will identify, monitor and evaluate gaps in the public health system and guide public health systems research to more effectively address CDC's prevention and health promotion objectives.

Significant Accomplishments

- Managed and expanded effective networks and partner relationships related to public health agencies, and other public health system partners.
- Managed and expanded effective networks and partner relationships related to public health and clinical laboratory partners.
- Provided support for CDC's Public Health Agency Portfolio Management pilot project, which includes developing and executing comprehensive, integrated, efficient, and effective action plans to achieve CDC's health protection goals with public health agencies in states and other specified jurisdictions.
- To facilitate building, maintaining, and extending the range of partnerships across CDC, established a partnership coordination database, with the state of New York serving as the pilot public health partner. The database will be expanded in 2005 to include all 50 states and other partners representing high-priority, cross-cutting relationships.

IMPROVING LABORATORY SYSTEMS

CDC is improving laboratory testing for specific diseases and conditions, as well as providing broad training and guidance to improve laboratory quality. In addition, CDC is working with the laboratory community to create a laboratory quality measurement and reporting system which will focus on information needed by specific audiences, including policy makers, professionals, and the public.

Current Activities

- CDC's Model Performance Evaluation Program (MPEP), a quality assessment program, continues to evaluate the quality of laboratory testing performance and assist in the development of strategies to identify and correct testing quality failures.
- CDC is supporting the development of the Institute for Quality in Laboratory Medicine (IQLM), a public-private partnership, to promote improvements in laboratory testing and services to benefit the health of the public. This Institute will foster partnerships among dozens of stakeholder organizations such as groups representing practitioners, payers, laboratories, device manufacturers, and patients. The first major IQLM conference will take place on April 28-30, 2005.
- CDC continues to provide leadership and assistance in the development of domestic and international laboratory practice standards and guidelines.
- CDC continues to provide international leadership and technical assistance in strengthening laboratory systems, increasing public health laboratory capacity, and assuring the reliability of laboratory services. Efforts target all international laboratories, resource-limited countries and laboratories in countries with emergency needs. Specific activities include: developing global standards for laboratory testing; creating partnerships with laboratory professional organizations, training organizations, and international assistance organizations; developing tools that can be used for assessing quality of laboratory systems and services, training, and standards development; working with in-country collaborators to design and implement plans to strengthen laboratories in their countries; and organizing and serving as technical experts in workshops and training events.

Significant Accomplishments

- In 2004, the MPEP programs reached approximately 1,600 U.S. public and private laboratories and more than 230 laboratories in 92 countries, and administered three questionnaire surveys to gather information on current laboratory practices for HIV antibody/viral load testing and HIV rapid testing.
- With the support of 39 partner organizations CDC sponsored the "Quality Institute (QI) Conference, "Making the Laboratory a Key Partner in Patient Safety." The purpose of the conference was to facilitate a better understanding of the impact of the quality of laboratory services upon healthcare and to explore opportunities to improve the delivery of laboratory services.
- Provided leadership and assistance in the development of the International Organization for Standardization (ISO) standard 15189 – "Medical Laboratories, Particular Requirements for Quality and Competence", which will be used as the model for country-wide standards throughout the world.
- Provided leadership in collaboration with the Association of Public Health Laboratories (APHL) and the American Society for Clinical Pathology in the development of laboratory training tools for use in the President's Emergency Plan for AIDS Relief (the "Emergency Plan") designated countries.

- Provided leadership in collaboration with WHO-AFRO and APHL to develop “Guidelines for Appropriate Evaluations of HIV Testing Technologies in Africa” for use in countries supported by Emergency Plan and the Global AIDS programs.
- Provided leadership in collaboration with WHO, APHL, and the International Union Against Tuberculosis and Lung Disease (IUATLD) to develop training tools for detecting TB and assuring the quality of test results.
- Assessed public health laboratory capacity in Pakistan and, in conjunction with WHO and the World Bank, developed an improvement plan.
- Provided leadership and technical assistance to Emergency Plan and GAP countries in the development of HIV/AIDS-related laboratory capacity and quality assurance implementation plans, particularly Botswana, Cambodia, Caribbean Epidemiology Center (CAREC), Ethiopia, Guyana, India (Tamil Nadu state), Malawi, Tanzania, Thailand, Vietnam, Zambia and Zimbabwe.

GENETIC LABORATORY TESTING

As genetic testing becomes more prevalent, CDC is working to ensure accurate laboratory tests and correct interpretation of test results.

Current Activities

- CDC is facilitating the development of laboratory and health provider networks to address public health concerns in assuring appropriate ordering, reporting, and use of genetic tests and results.
- CDC, in collaboration with national and international partners, is participating in an assessment of molecular genetic testing laboratory practice. This assessment is the first step in understanding and eventually developing assurances that appropriate sampling and referral measures are in place both domestically and internationally.
- CDC, in collaboration with the genetic testing community, is assisting with efforts to identify needed materials for quality control, and with collection, verification, storage, and distribution of the most needed materials to the testing community.

Significant Accomplishments

- Co-hosted a national conference entitled “Communication: Key to Appropriate Genetic Test Referral, Result Reporting and Interpretation.” This conference assembled a multidisciplinary group of clinical and public health practitioners, laboratory professionals, payers, policy makers, and others to develop recommendations for improving practices for ordering and using genetic tests and results.
- In May 2004, CDC convened a conference entitled “Promoting Quality Laboratory Testing for Rare Diseases: Keys to Ensuring Quality Genetic Testing.” This conference brought together a broad scope of stakeholders to address crucial issues surrounding the availability of and access to quality genetic testing for rare diseases.
- CDC, along with other key members of the health care industry, hosted three conferences entitled “QC Materials for Genetic Testing.” These conferences were held to develop recommendations relative to current and future needs for genetic testing QC materials and establish a sustainable, practical process to make QC materials available to genetic testing laboratories.
- Through a cooperative agreement with Dartmouth Medical School, CDC developed “Genetics in Clinical Practice: A Team Approach,” an interactive educational tool that emphasizes the uniqueness of the genetic testing process and increases the knowledge of healthcare providers using genetic tests in clinical practice. The CD-ROM version, which won the 2004 Federal Laboratory Consortium (FLC) Award for Excellence in Technology Transfer is distributed through the American College of Medical Genetics and the American Medical Association, and was sent to all U.S. medical schools.

NATIONAL LABORATORY SYSTEM (NLS)

The nation’s well-being depends upon on timely identification of disease outbreaks and environmental events; rapid communication and dissemination of pertinent information; and containment of any adverse results. CDC, working with the APHL, is developing the NLS, an enhanced communication and collaboration network among public health and clinical laboratories. The NLS will facilitate effective detection of public health threats and provide timely reports of such threats to minimize any negative impact of such health events.

Current Activities

- CDC continues to promote the core functions and capabilities of state public health laboratories and is collaborating with APHL to develop key indicators for Healthy People 2010 and performance standards for state public health laboratories.
- CDC is continuing to support the Washington State “Clinical Laboratory Initiative,” an academic-based demonstration project that includes assessing and improving laboratory practices for antimicrobial susceptibility testing in a multi-state region with an emphasis on small and limited resource laboratories. Educational intervention strategies have been developed and are being implemented to address deficiencies noted in the assessments.

Significant Accomplishments

- A 1% formative evaluation of the four NLS pilot projects was completed and concluded that only through sustained, focused communication efforts can the needs of public health organizations to guard the public health be met. Based on case study results, it was recommended that the NLS concept be advanced through a more aggressive developmental plan.
- The NLS concept was expanded to 10 additional states under APHL’s “Public-Private Laboratory Integration Project.”

NATIONAL LABORATORY DATABASE (NLD)

CDC’s NLD is maintained in cooperation with the Centers for Medicare and Medicaid Services (CMS) and Veterans Administration. The NLD is a flexible system that cross-references CMS laboratory data with input from proficiency testing providers to produce ad hoc reports of clinical laboratory demographics and testing capacities. Access to this database by state public health laboratories enhances their ability to identify, communicate, and share relevant data and information with other laboratories in their states.

Current Activities

- CDC is collaborating with APHL’s Knowledge Management Committee to promote the NLD and establish parameters to create customizable state databases.
- Two CDC and APHL workgroups are addressing expansion of the NLD to include more specific information on the nation’s laboratory testing capacities related to potential agents of biological and chemical terrorism and molecular diagnostics for emerging infectious agents.

Significant Accomplishments

- Access to the NLD increased from 17 to 33 states in 2003 and from 33 to 49 states and the District of Columbia in 2004.
- Emergency room demographics and data were added to the searchable elements of the NLD.
- Clinical laboratories performing influenza testing were identified.
- To facilitate systematic improvements, a customer survey process was established to identify and address NLD-user satisfaction, concerns, and needs.
- CDC collaborated with APHL’s Knowledge Management Committee to develop a uniform definition of the Laboratory Response Network (LRN) sentinel laboratories.

NATIONAL CENTER FOR PUBLIC HEALTH LABORATORY LEADERSHIP (NCPHLL)

NCPHLL was established by CDC and APHL to prepare current and emerging laboratory leaders with strategy and decision-making skills to strengthen the capacity and performance of the nation’s public health laboratory system. The goal of the center is to design, implement, and coordinate an array of activities that build leadership capacities and strengthen administrative, scientific, and technical skills within public health laboratories.

Current Activities

- CDC continues a series of leadership forums throughout the country to introduce itself to stakeholders and develop and promote best practices for public health laboratory administration.

- CDC continues to provide training activities for grant writing to benefit public health laboratories, and media skills for public health laboratory directors in emergency and non-emergency situations and a course on preparing the laboratory for Select Agent inspection.
- CDC continues to provide an orientation program for new state laboratory directors.

Significant Accomplishments

- Finalized a new laboratory director orientation manual, "Practical Guide to Public Health Laboratory Leadership."
- Performed a first-ever assessment of local public health laboratory capacity and knowledge of emergency preparedness & response, and CDC's LRN.
- Initiated and conducted the first "New Public Health Laboratory Directors Orientation Program".

PUBLIC HEALTH SYSTEM DEVELOPMENT

CDC is conducting research to support the development of innovative public health systems that include the participation of diverse stakeholders in improving the public's health. The National Public Health Performance Standards Program (NPHPSP) is a partnership initiative to improve the practice of public health and the performance of public health systems. Through the use of optimal standards, public health agencies and their system partners can identify strengths and weaknesses and make improvements in performance, infrastructure, and quality of public health services.

Current Activities

- CDC is working with national partners to support implementation of the state public health system, local public health system, and local governing body assessment instruments; to analyze and disseminate the performance data, and to promote systems improvement activities.
- Currently 10 states and their local jurisdictions are preparing to use the instruments and are expected to complete the process in the 2004-2005 timeframe.

Significant Accomplishments

- Since national implementation began in July 2003, five states and 250 localities have used the instruments and submitted data to CDC.

PUBLIC AND PRIVATE PARTNERSHIPS

Many activities essential to disease prevention and health promotion occur outside of the traditional public health sector – in businesses, health care organizations, educational institutions, other Federal agencies, and faith-based organizations. To date, CDC has not had a systematic agency-wide approach to engage these organizations in CDC's health impact goals. With a special focus to public and private partnerships, the new health marketing center provides staff and resources to enable the agency to engage these sectors more rapidly and effectively in health promotion and disease prevention.

Current Activities

- CDC is developing sector strategies for CDC's major cross-cutting goals. These sector strategies will indicate how CDC can engage businesses, health care organizations, educational institutions, other Federal agencies, and faith-based organizations in achieving the goals. These strategies will identify partners that have the greatest potential impact for the CDC goals in the various sectors.
- For high-priority, cross-cutting relationships, CDC is developing and maintaining a partnership coordination database containing general background information about the partners and details related to current CDC interactions, partner organization and leadership, and key CDC and partner contacts.
- To understand the needs, perspectives, and priorities of outside sectors, CDC supports a "sector intelligence" activity involving systematic environmental scanning and provision of just-in-time information to CDC programs and sector partners based on the gathered intelligence. This information is highlighted and maintained in the partnership coordination database.

Significant Accomplishments

- CDC successfully managed cooperative agreements with America's Health Insurance Plans, the National Business Group on Health, the national Business Coalition on Health, and the Alliance of Community Health Plans.
- As part of the White House's Faith-Based and Community Initiative, CDC supported the Institute for Public Health and Faith Collaborations at Emory University's Rollins School of Public Health. The Institute creates a unique learning model and environment for leaders from both practice fields to develop skills for aligning and leveraging the respective strengths of the public health and faith-based communities.
- For the partnership coordination database, CDC developed detailed information about CDC-wide interactions with three partners representing key public and private sectors: American Association of Retired Persons, CMS, and General Electric.

PUBLIC HEALTH COMMUNICATIONS

CDC's Health Marketing activity provides leadership in the development of CDC principles, strategies, and practices for effective communication to the public. It also functions as a CDC-wide forum for discussion, development, and adoption of emergency and "long-lead" (e.g., feature magazine articles and television drama storylines) health communication policies and procedures. This activity also coordinates intramural and extramural communication research, provides communication infrastructure, shares timely communication to the public through such channels as the CDC Web site, a centralized exhibit management function, CDC's new Consumer Response System (CRS) (1-800-CDC-INFO) and the CDC Visitor and Education Center, and assures rapid and accurate information provision during times of emergency and terrorism.

Current Activities

- CDC is developing innovative communication training for public health workers through CDCynergy, an interactive training tool. CDCynergy integrates theories, frameworks, and approaches from behavioral science, risk communication, social marketing, and health education to teach practitioners effective ways to use marketing and communication to promote health.
- The Emergency Communications System (ECS) coordinates, manages, and disseminates communication materials addressing emergency situations. As part of this ongoing activity, the ECS fosters partnerships and creates channels to effectively disseminate critical emergency communication to specific audiences.
- The Epidemic Information Exchange, Epi-X, provides a secure, moderated, Web-based exchange for public health officials to report and discuss disease outbreaks and other health events, particularly those potentially related to terrorism, as they are identified and investigated. Epi-X works in partnership with state and local health departments, HHS, CDC, the Office of the Surgeon General, FDA, USDA, EPA, DoD, and DoS.
- CDC's new CRS provides culturally and educationally appropriate information on priority health topics through integrated telephone hotline and web-based communications. The CRS centralizes and streamlines response services throughout CDC, which previously were provided through 40 separately promoted 800 numbers. The CRS affords improved consistency, comprehensiveness, and packaging of health messages; expanded coverage and surge capacity; enhanced language capability; and more detailed and systematic customer feedback and evaluation.
- To optimally fulfill CDC's commitment to communicate health information that is relevant and accessible to people in different life stages (e.g., adolescents, older adults), CDC conducts communication research to assess the public's understanding, needs, and receptiveness to single and combined health messages, and is assembling the findings of customer research conducted throughout CDC in a Web-based Consumer Insights Database.
- "Long-lead" media activities focus on (1) responding to requests from writers, producers, and researchers in the mass media, connecting them with CDC experts who can lend credibility to any documentary, print article, or entertainment program, and (2) proactively reaching and engaging members of the public in their everyday lives, beyond the crisis, the breaking news, and the short deadlines. Through a cooperative agreement with the University of Southern California Annenberg Norman Lear Center, CDC and NIH's National Cancer Institute are supporting the Hollywood, Health, and Society "edutainment" project to increase the amount and quality of health-related information appearing in the entertainment media. This project supplies writers and producers of all types of entertainment content with accurate health information through individual briefings, special seminars, web-based resources, and expert consultation.

- The Executive Communication Council (ECC) sets agency communication policy, evaluation standards, and performance metrics for all CDC health communication strategies, engages in cross-agency resource and strategic planning, provides leadership for Center, Institute and Office (CIO) based communication activities, ensures that policies and standards set by ECC are applied in CIO communication initiatives, and engages in decisions regarding collaborative use of agency-wide communication staff to support priority goals.

Significant Accomplishments

- CDCynergy has been published in eleven different customized versions (e.g., Basic Edition, Emergency Risk Communication, Social Marketing, and special editions for tobacco prevention, micronutrients, cardiovascular health, immunizations, diabetes, STD prevention), with five editions in production (malaria, environmental health, violence prevention, 5-a-Day, and diabetes prevention among American Indians/Alaska Natives).
- CDC's Web site continues to serve as a critical channel for communicating health information to the public, logging more than 11 million visits a month during 2004. Web redesign work continued, with the goal of developing easily accessible consumer pages for each priority CDC health topic. Overall consumer satisfaction with the CDC site was 74% in 2004, compared to the Government-wide benchmark of 70%.
- ECS ensured that CDC information related to key health crisis situations in 2004 – most notably, the U.S. flu vaccination shortage and the December 26 earthquake and tsunami – was accurate, internally consistent, timely, and coordinated with CDC partners responding to these emergency events.
- CRS was launched in 2004, with four major CDC information services preparing to migrate to the CRS in early 2005: emergency preparedness, HIV/AIDS, STDs, and immunization. Additional health topics (e.g., tobacco control, cancer prevention, infectious diseases) will be added incrementally over a three year period to ensure quality control of new and revised content and continuity of service during the transition phase to a single toll-free telephone number.
- CDC's Sentinel Awards, a special project of the Hollywood, Health, and Society initiative, was expanded in 2004 to recognize exemplary health-related storylines in prime-time dramas and comedies in addition to daytime soap operas. At the fifth annual awards ceremony held at the Writers Guild of America in Los Angeles, the NBC drama *Law & Order: Special Victims Unit* received first place in prime-time drama for a storyline on fetal alcohol syndrome. The CBS soap opera *The Young & The Restless* took first place in daytime drama for a storyline about a teen with chlamydia. The UPN show *One on One* took first place in prime time comedy for a storyline about alcoholism.
- The ECC developed CDC-wide activities to minimize the risk of influenza transmission through vaccination programs targeting highly vulnerable populations and advocating health behaviors to minimize the risks of spreading the influenza virus and to optimize respiratory health. The ECC also worked to develop agency-wide and topic-specific promotion activities related to the *Guide to Community Preventive Services* to increase awareness and adoption of the guide's best practices for community public health interventions, impacting numerous health outcomes.
- In FY 2004, Epi-X posted 1,333 reports of outbreaks, Epi-Aids, and notification tests including reports on avian influenza provided by Thailand, guidelines for influenza vaccine use in the U.S., diphtheria, and fatal rabies cases. Improvements in the system allowed reports to be targeted to selected persons only, and daily media tracking reports summarizing worldwide events of public health importance were begun. Epi-X staff successfully completed the first state-by-state nationwide notification proficiency testing conducted by CDC, a year-long process requiring the collaboration of 50 state health departments and three major metropolitan areas.

PUBLIC HEALTH TRAINING

Over the last decade, CDC has developed a national distance learning system to train public health workers in all disciplines. The Public Health Training Network (PHTN) is continuing to expand its collaboration with national and international partners to develop and implement global e-learning systems for delivery of education and information to health professionals worldwide.

Current Activities

- The PHTN is enhancing e-systems for expanded learner support by enlarging the current online, web-accessible CDC training catalogue to encompass all CDC-accredited training and educational programs.
- CDC is working to increase its array of partners who market and deliver CDC programs as well as other health-related education and information.

- CDC develops and collaborates with partners who design and deliver instructional programs to health professionals globally (including 1.8M health professionals in China) during 2003 and 2004. Health professionals benefit from just-in-time/just-in-case programs on SARS, ricin, chemical terrorism, plague, HIV, radiation, and food safety.
- *Global Learning Systems (GLS)*: CDC collaborates with Japan, China, Canada, nine countries in Central and Eastern Europe, and the Pacific Island region to provide sustained capacity for distance learning activities. CDC global distance learning programs and products reach registered healthcare professionals in 73 nations.

Significant Accomplishments

- Since April 2003, PHTN produced 30 interactive satellite-based instructional programs, 28 videos, and 42 instructional multimedia programs reaching more than 250,000 public and private health workers at state and local levels. These competency-based programs carry professional accreditation for clinicians, nurses, health educators, and other professionals. Since April 2003, the PHTN has seen a 30 percent increase in the number of health professionals accessing accredited education on-line.
- As new cases of SARS erupted in the spring of 2004, CDC developed a new program to warn laboratorians and researchers worldwide about precautions and preventive measures in working with the SARS virus. As of the summer of 2004, these broadcasts have been viewed by more than 234,000 U.S. health professionals. CDC information about SARS has helped to prevent this deadly disease from becoming an epidemic.

SCIENTIFIC HEALTH COMMUNICATIONS

CDC's main channel to communicate public health news about disease outbreaks and trends in health and health behavior is a family of publications that includes the *MMWR Recommendations and Reports*, *MMWR Surveillance Summaries*, and the *MMWR Annual Summary of Notifiable Diseases*. These reports, available in print and online, contribute to the successful planning of programs and interventions by providing essential, evidence-based information for both professional and public use. CDC's online continuing education program for physicians, nurses, and public health practitioners was developed in response to the demand for more continuing education for the public health workforce. The *MMWR* continuing education program (CEP) provides electronic and paper text testing delivered simultaneously with the electronic and paper editions of the *MMWR*.

Current Activities

- The *MMWR* Web site (www.cdc.gov/mmwr/) receives, on average, 12 to 13 million hits per month. During periods of time when there are urgent public health concerns, such as during the height of SARS outbreak in early 2003 and the outbreak of monkeypox in the same period, the number of hits increases dramatically.
- CDC distributes its flagship publication, the weekly *MMWR*, in paper and electronic format to more than two million persons annually.
- Clinicians and other public health professionals recognize *MMWR* as the authoritative CDC "voice" and turn to the publication when they want the final word on important health topics, especially during national emergencies. During times of national crisis, *MMWR* immediately publishes online important health information, such as reports of terrorism and other breaking health news. *MMWR Online* also includes the *MMWR M Guide*, a concise, electronic "handbook" that brings together all CDC reports on a single health topic.

Significant Accomplishments

- The *M Guide* on SARS received 80,000-120,000 visitors per day during peak periods. In the print edition of *MMWR*, the *MMWR QuickGuide*, a new insert feature, provides prevention and treatment guidelines in a compact, detachable design. The first *QuickGuide*, "Recommended Childhood and Adolescent Immunization Schedule – United States, 2003," has provided thousands of clinicians and health care providers with a portable, useful tool.
- As of December 2004, *MMWR* published 15 issues of *MMWR Recommendations and Reports* and eight issues of *MMWR Surveillance Summaries*.
- During FY 2004, *MMWR* also published a special supplement to the series, a collection of peer-reviewed papers from the international conference on syndromic surveillance, totaling 264 pages.

PUBLIC HEALTH SCIENCES

It is essential to assure that public health programs and policies produce important benefits, and that these benefits can be achieved at a reasonable cost. CDC engages in applied research and methods development activities in various areas such as economic analysis, systematic reviews, performance measurement, burden of disease estimation, and intervention implementation and evaluation. CDC utilizes *The Guide to Community Preventive Services (Community Guide)* led by the Task Force on Community Preventive Services, and the Prevention Effectiveness and Health Economics Program to evaluate and communicate what is known about the effectiveness, economic efficiency, and feasibility of interventions to promote community health and prevent disease. Additionally, CDC was charged with developing guidance to provide information to public health authorities and their authorized agents, researchers, and healthcare providers in interpreting the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as it affects public health to ensure that implementation of the rule is consistent with its intent to protect privacy while permitting authorized public health activities to continue.

Current Activities

CDC provides scientific and other support to the independent, non-federal Task Force on Community Preventive Services. CDC and the Task Force identify, evaluate, summarize, and communicate critical evidence-based information regarding the effects of interventions, their applicability to specific populations and settings, potential barriers to implementation, and the costs and cost-effectiveness of their implementation. In addition, the Task Force provides public health decision-makers with independent, objective, and evidence-based recommendations for practice, policy, and research. The Task Force focuses on population-based interventions to promote health, prevent morbidity, and premature mortality.

Significant Accomplishments

- In 2004, CDC conducted and led research in economic analyses of public health interventions including methods for systematic reviews of economic evaluations, health inequalities in the United States, and assessing preferences for prevention versus treatment using willingness to pay and cost of illness of infectious diseases.
- In 2004, the *Community Guide* issued several new publications on cancer prevention and motor vehicle occupant injury prevention; submitted to a leading scientific publisher the book version of the *Community Guide* summarizing methods, approximately 120 findings, and how to use them in an accessible form for decision makers; and developed several products that facilitate awareness and use of the recommendations, including a Public Health Grand Rounds program summarizing Onandaga County's (New York) use of *Community Guide* tobacco control materials by state and local health departments, and use of the *Community Guide* as a way to help the United Health Foundation make its 2004 state health rankings more actionable.

RATIONALE FOR THE BUDGET

The FY 2006 budget request of \$46,545,000 for Health Marketing represents an increase of \$23,000 over the FY 2005 Enacted level of \$46,522,000.

OUTPUT TABLE

OUTPUT TABLE	FY 2004 ACTUAL	FY 2005 APPROPRIATION	FY 2006 ESTIMATE	FY 2006+/- FY 2005
Number of MMWR Publications	90	76	76	0
Number of Published Community Guide Findings annually	25	25	30	5
Public Health Communications				
Internet-accessible Public Health Image Library scientific/disease reference images (Media Asset Management System)	6,150	6,800	7,800	1,000
Number of monthly visits to CDC Web site	11 million	11.5 million	12 million	.5 million
Customer satisfaction with CDC Web site	74%	77%	80%	3%
Number of monthly calls to 800-CDC-INFO	--	Baseline	Baseline +20%	20%

NARRATIVE JUSTIFICATIONS
HEALTH INFORMATION AND SERVICE
HEALTH MARKETING

OUTPUT TABLE	FY 2004 ACTUAL	FY 2005 APPROPRIATION	FY 2006 ESTIMATE	FY 2006+/- FY 2005
Customer satisfaction with 800-CDC-INFO	--	Baseline	Baseline +3%	3%
Public health workers trained in CDCynergy	--	Baseline	Baseline +10%	10%
Programs produced for broadcast on CDC-TV	--	26	52	26
CDC-wide priority campaigns coordinated through Executive Communications Council	--	2	3	1
Reports of outbreaks reported by Epi-X	1,300	1,400	1,450	50
Public Health, Public, and Private Partnerships				
Partners included in partnership coordination database	4 (prototype)	60	100	40
CDC users of partnership coordination database	--	Baseline	Baseline +25%	25%

ENVIRONMENTAL HEALTH AND INJURY

Environmental Health and Injury (Dollars in Thousands)	FY 2004 Actual	FY 2005 Enacted	FY 2006 Estimate	FY 2006 +/- FY 2005
BA	\$282,925	\$285,721	\$284,820	(\$902)
FTE	410	396	396	0

INTRODUCTION

The Environmental Health and Injury Prevention budget activity is responsible for the planning, direction, and coordination of national and global public health research and programs that maximize health and minimize illness, disability, and/or death caused by environmental exposures or injuries. In carrying out this mission, CDC promotes excellence in public health science and programs across all activities related to Environmental Health and Injury Prevention, assures the establishment of priorities related to Environmental Health and Injury Prevention goals, coordinates their alignment with CDC and HHS priorities, and assures that Environmental Health and Injury Prevention resources are aligned with these priorities and goals. CDC also identifies synergies related to environmental health and injury prevention and control across CDC, while assuring that CDC meets statutory and mandated requirements.

Many of the public health successes that were achieved in the 20th century can be traced to innovations in environmental health practices. However, emerging pathogens and environmental toxins continue to pose risks to our health and significant challenges to public health. The task of protecting people's health from hazards in their environment requires a broad set of tools. Principal among these tools is surveillance and data collection to determine which substances in the environment are affecting people and to what degree. The determination must be made as to whether these substances are harmful to humans and at what level of exposure.

CDC is the lead Federal agency for injury prevention and control. Programs are designed to prevent premature death and disability and reduce human suffering and medical costs caused by fires and burns; poisoning; drowning; violence; lack of bicycle helmet use; lack of seatbelt and proper baby seat use; and other injuries. Injury prevention and control activities at CDC encompass non-occupational injury and applied research in acute care and rehabilitation of the injured. Funds are utilized for both intramural and extramural research as well as assisting state and local health agencies in implementing injury prevention programs.

ENVIRONMENTAL HEALTH

AUTHORIZING LEGISLATION

PHSA §§ 301, 307, 310, 311, 317, 317A, 317B, 317I, 327, 352, 1102; Housing and Community Development Act, 1021 (15 U.S.C. 2685).

Environmental Health (Dollars in Thousands)	FY 2004 Actual	FY 2005 Enacted	FY 2006 Estimate	FY 2006 +/- FY 2005
BA	\$146,458	\$147,484	\$146,888	(\$596)

STATEMENT OF THE BUDGET

The FY 2006 budget request of \$146,888,000 for Environmental Health represents decrease of \$596,000 below the FY 2005 Enacted level of \$147,484,000.

PROGRAM DESCRIPTION

CDC's Environmental Health program was established in 1980 to focus on preventing disability, disease, and death caused by environmental factors.

Today, CDC uses a combination of science, service, and partnerships to protect human health from environmental hazards by investigating the effects of the environment on health through laboratory and field research; tracking and evaluating environment-related health problems through surveillance systems; developing and implementing interventions and preventative actions; and helping domestic and international agencies and organizations prepare for and respond to environmental emergencies.

CDC recently consolidated its Offices of the Director for the National Center for Environmental Health and the Agency for Toxic Substances and Disease Registry. The two public health programs now share a management team and support staff.

GOALS

- Determine human health effects associated with environmental exposures.
- Prevent or reduce illnesses, injury, and death related to environmental risk factors.
- Build and enhance effective partnerships to improve environmental health capacity.
- Promote effective and efficient management.

Funding for Environmental Health for the last five years:

FY	FUNDING*
2001	\$137,255,000
2002	\$153,398,000
2003	\$182,829,000
2004	\$146,458,000
2005	\$147,484,000

*FY 2004 and FY 2005 funding levels reflect the removal of management and administrative costs under the new budget structure. FY 2001-2003 funding levels are not available in the new structure and include management and administrative costs.

PERFORMANCE ANALYSIS

GOAL: DETERMINE HUMAN HEALTH EFFECTS ASSOCIATED WITH ENVIRONMENTAL EXPOSURES.

NATIONAL BIOMONITORING PROGRAM

Biomonitoring is the standard for assessing the exposure of people to toxic substances. It consists of measuring the levels of environmental chemicals in a person's blood or urine. For more than three decades, CDC's laboratory scientists have been determining which environmental chemicals people have been exposed to, how much of these chemicals enter their bodies and stay long enough to be detected, and what levels of chemicals in their bodies are related to health effects.

Current Activities

- Assessed exposures ranging from those causing deaths during acute emergencies to exposures that may cause cancer, birth defects, or neurological or other diseases.
- Published CDC's *Second National Report on Human Exposure to Environmental Chemicals (Second Report)*. The *Report* contained data on 116 chemicals, including updated information on the 27 chemicals in the *First Report* and first-time data on an additional 89 chemicals.
- Developed and validated analytical methods to measure speciated forms of arsenic, mercury, and acrylamide in people and to measure human exposure to perchlorate (used in the production of explosives and fireworks), and perfluorinated compounds (used to protect surfaces of fabric, leather, upholstery, carpet, and paper).
- Certified the proficiency of other laboratories for measurement of substances in blood and urine:
 - In FY 2003, six manufacturers received certification for 20 unique analytical systems for measuring total cholesterol, five manufacturers received certification for 18 unique analytical systems for measuring high-density lipoprotein cholesterol, and one manufacturer received certification for six unique analytical systems for measuring low-density lipoprotein cholesterol.
 - In FY 2003, 446 clinical laboratories participated in the clinical laboratory certification program (including multiple attempts by individual laboratories). The Cholesterol Reference Method Laboratory Network (CRMLN) issued 383 Certificates of Traceability. Of these, 241 were issued to U.S. clinical laboratories. Two major clinical laboratory consortia (Quest Diagnostics and Laboratory Corporation of America) are regular participants in the certification program.

Significant Accomplishments

- Data published in the *Second Report* demonstrated CDC's success on several fronts:
 - The percentage of children with blood lead levels (BLLs) above the ten micrograms per deciliter (ug/dl) threshold has fallen from an estimated 4.4 percent in 1991–1994 to 2.2 percent in 1999–2000.
 - Exposure of nonsmokers to second-hand tobacco smoke has declined. To date, testing of people aged 3 years and older show a minimum 70 percent decrease in the median cotinine (a metabolite of tobacco smoke) levels in 1999–2000 from the levels of 1991–1994.
 - Public exposure to the insecticide DDT is now much lower than in the past.
 - Testing efforts have revealed that levels of DDE (a breakdown product of DDT) are three times higher among Mexican-Americans than among non-Hispanics. Discovering this once-hidden fact means that the relatively high exposure rate in this population can now be addressed.
- CRMLN laboratories maintained outstanding performance with the Abell-Kendall reference method for measuring cholesterol levels and the designated comparison method for measuring high-density lipoprotein cholesterol.
- The DNA of case and control children has been genotyped for a gene variant associated with secondary leukemia in children who have been treated with 6-mercaptopurine.

NATIONAL ENVIRONMENTAL PUBLIC HEALTH TRACKING PROGRAM

CDC established its National Environmental Public Health Tracking Program during FY 2002. The program's general aim is to provide federal, state, and local agencies with data that will enable them to be better prepared to develop

and evaluate effective public health actions related to preventing or mitigating health effects from exposure to environmental hazards.

The data also help health care providers to offer more targeted and preventive services. In addition, the data facilitate better public understanding of health trends and events in their communities and of actions they can take to protect and improve their health.

Current Activities

In FY 2004, CDC worked with 21 states, three cities, and three academic institutions, as well as with other governmental and non-governmental organizations, to lay the groundwork for the National Environmental Public Health Tracking Network. Activities range from planning and capacity-building to methods development and epidemiologic research, and a total of 17 awards focusing on data linkage (environmental hazards, exposures and health effects) demonstration projects in 12 states and one municipality.

Significant Accomplishments

- A study revealed that reporting by school nurses provides much better estimates of asthma prevalence and exacerbation than traditional methods (Massachusetts).
- An examination of spatial trends of asthma distribution disproved the widely held belief that poorer neighborhoods were disproportionately impacted (Massachusetts).
- A study showed that canned albacore tuna contained three times more mercury than light tuna. As a result, Washington State posted advisories for pregnant women and young children to reduce the risk of developmental problems associated with consumption of large amounts of mercury-containing tuna.
- Spatial analysis identified several areas in St. Louis that will undergo more intensive investigation of health impacts related to airborne lead.

ENVIRONMENTAL HAZARDS AND HEALTH EFFECTS PROGRAM

Through its Environmental Hazards and Health Effects Program, CDC investigates the human health effects of exposure to environmental hazards ranging from *Pfiesteria* and other harmful algae, chemical pollutants, air pollutants, mold, and radiation to natural, technologic, or terrorist disasters. The results of these investigations are used to develop, implement, and evaluate actions and strategies for preventing or reducing harmful exposures and their consequences.

PFIESTERIA AND OTHER POTENTIALLY HARMFUL ALGAE

Current Activities and Significant Accomplishments

- CDC is working with public health agencies, universities, and federal partners to investigate whether and how algae (e.g., *Pfiesteria*, cyanobacteria, and algae that cause red tides), may affect human health.
- CDC is studying human exposure to drinking water that contains microcystin, a cyanobacterial toxin that can affect the liver; and measuring changes in lung function of humans who have breathed air that contains marine toxins.
- CDC is providing technical assistance to a study of whether residential filtration systems remove cyanobacterial toxins from drinking water.

CANCER CLUSTERS

Current Activities and Significant Accomplishments

- To assist the public, states, public health partners, decision makers, and others, CDC provides educational information, operates a public inquiry response system on cancer cluster issues, and provides technical assistance to states in responding to those issues. CDC assisted the state of Nevada in a study of childhood leukemia in Fallon, Churchill County, Nevada, the most extensive study of a cancer cluster ever conducted. CDC successfully identified exposures of concern in and around Fallon, spurring the state to take action to prevent community exposures to arsenic and pesticides. In addition, CDC's efforts have prompted the National Toxicology Program to consider tungsten as a priority chemical for toxicological testing.
- CDC is assisting state officials in Sierra Vista, Arizona regarding a possible childhood leukemia cluster in the community. So far, CDC has provided the state with a) information concerning scientific approaches to

leukemia cluster investigations and answers to specific questions; and b) all reports and the protocol for the Churchill County Childhood Leukemia Study. CDC will provide technical assistance in collecting, analyzing, and banking biological samples from the Sierra Vista children with leukemia.

CHEMICALS

Current Activities and Significant Accomplishments

- CDC is collaborating with the American Association of Poison Control Centers (AAPCC) to modify its Toxic Exposure Surveillance System (TESS) into a pre- and post-event surveillance tool for rapid identification and response to chemical poisoning events, both unintentional and intentional in nature. CDC and AAPCC are presently evaluating TESS to see how it can detect small, hard-to-recognize events.
- Recently, TESS detected intentional arsenic poisoning in Maine of 16 church members, demonstrating that the system can detect chemical exposures even among a small group of people.
- To address public concerns, CDC conducted a study in Mississippi to determine if mosquito-control spraying during the West Nile virus epidemic increased the amount of pesticides to which people were being exposed. In Mississippi, CDC found that mosquito-control spraying did not significantly increase human exposure to pesticides.
- CDC conducted a study to assess pesticide exposure in children living in Yuma County, Arizona. The study was performed to determine whether children who lived or attended school close to agricultural fields had higher levels of pesticides in their urine than did children who lived or attended school further away. In Arizona, CDC found that exposure to pesticides in the household was more closely related to levels of pesticide metabolites measured in urine than the distance the child lived or attended school from an agricultural field. As a result, public health efforts can now focus on appropriate measures.

GOAL: PREVENT OR REDUCE ILLNESSES, INJURY, AND DEATH RELATED TO ENVIRONMENTAL RISK FACTORS.

NATIONAL ASTHMA CONTROL PROGRAM

CDC's National Asthma Control Program was developed to assist people with managing their asthma. Although the cause of asthma is unknown, genetic and environmental factors are thought to be involved. Currently, no known method prevents the initial onset of asthma, and there is no cure. However, much is known about how to control asthma.

CDC supports asthma data tracking, interventions and partnerships nationwide. CDC's National Asthma Control Program aims to reduce the number of deaths, hospitalizations, emergency department visits, school or workdays missed, and limitations on activity due to asthma.

Current Activities

- In FY 2004, the program funded 37 states, nine cities, Puerto Rico, and a number of other partners – including other Federal agencies, universities, and national organizations – for asthma-related activities. These grantees and CDC are conducting seven asthma tracking projects, 49 intervention, 39 partnership, three public health research, and seven directed-source funding projects.
- In partnership with CDC's school health program, the asthma program funded seven urban school districts, one state education agency, and six national nongovernmental organizations to support and address asthma control within a coordinated school health program. These activities identify those most affected by uncontrolled asthma and help CDC build partnerships to provide interventions to those most in need.
- The Asthma Program supports interventions shown to reduce the burden of asthma. For example, the Inner City Asthma Intervention provides urban families with asthma education and individualized asthma control plans.
- CDC provides evaluated intervention resources on its website and funds grantees to conduct projects related to evaluated interventions, such as replication and implementation of scientifically proven asthma interventions.
- CDC partners with national organizations (e.g., the American Lung Association, Asthma and Allergy Foundation of American, and the Allergy and Asthma Network Mothers of Asthmatics) to conduct activities related to asthma education. These activities range from identifying effective educational programs for adults to educating children with asthma and their families and caregivers.

CHILDHOOD LEAD POISONING PROGRAM

Childhood lead poisoning remains a major preventable environmental health problem, especially among poor, inner-city and minority children. Childhood lead poisoning was recognized as a public health crisis in the United States between the years of 1976–1980, when analysis of BLLs (blood lead levels) in children from the *National Health and Nutrition Examination Survey II* (NHANES II) revealed that 88 percent of children from one to five years of age had BLLs of 10µg/dL or higher.

Children from low-income backgrounds, especially racial and ethnic minorities living in substandard, poorly maintained housing built before 1950, are at highest risk for lead exposure. Nearly 22 percent of non-Hispanic black children living in homes built before 1946 have elevated BLLs.

Current Activities and Significant Accomplishments

- Developed the Childhood Blood Lead Surveillance System, which is now used by 46 states to report relevant data.
- Funded nearly 60 childhood lead poisoning prevention programs to develop, implement, and evaluate lead poisoning prevention activities.
- Expanded public health laboratory capacity in states to analyze blood and environmental samples and to ensure timely, accurate, and high-quality analysis of results.
- Helped develop the Lead Topic Area Web site, designed as a portal to CDC's storehouse of information on lead and lead poisoning.

CHEMICAL WEAPONS DEMILITARIZATION AND DISPOSAL PROGRAM

Public Law 99-145 (1986) requires HHS/CDC to review the Department of Defense's (DoD's) "particulars and plans" for the transportation and disposal of lethal chemical weapons and provide recommendations to protect the public health. CDC's goal is to eliminate potential exposures to, and health effects from, nerve and blister agents among workers and the surrounding communities.

Current Activities and Significant Accomplishments

- Recommended reduced airborne exposure limits for tabun, sarin, and VX at chemical demilitarization sites. DoD accepted recommendations for reduced airborne exposure limits. DoD will implement recommendations for tabun, sarin, and VX in FY 2005 and for sulfur mustard in FY 2006. The result of this change will be to further limit potential exposures to nerve agents and to sulfur mustard among workers and the surrounding populations.
- Continued work on previous recommendations made for Umatilla Chemical Agent Disposal Facility. DoD has carried out program recommendations for improved air monitoring procedures and technologies at the Umatilla Chemical Agent Disposal Facility in FY 2004; other changes to the air monitoring program are also underway in order to implement the revised airborne exposure limits in FY 2005 and FY 2006.

ENVIRONMENTAL HEALTH SERVICES PROGRAM

Environmental Health Services (EHS) activities strive to strengthen the role of state, local, and national environmental health programs and professionals to better anticipate, identify, and respond to adverse environmental exposures and the consequences of these exposures to human health. Environmental Public Health (EPH) services, though necessary at all levels, are mainly carried out at the local level (i.e., food safety, vector control, water and sanitation, indoor air quality, etc.) and are provided by front-line environmental health professionals.

Current Activities

- Increases environmental public health capacity at all levels of government.
- Supports relevant research and evaluation.
- Develops and enhances the EPH workforce.
- Provides technical assistance and consultation to EPH programs and training, education, and scientific information to environmental health professionals.
- Funds six schools of public health to serve to assist state and local health departments in developing effective environmental public health programs. These programs are aimed at improving public health

response to current and emerging health threats and at expanding the science base in environmental public health to improve public health practice.

- Provides technical assistance and information to a total of more than 2025 state, local, and tribal environmental health programs throughout the U.S.

INTERNATIONAL EMERGENCY AND REFUGEE HEALTH PROGRAM

The International Emergency and Refugee Health Program (IERH) brings public health and epidemiologic principles to the aid of populations affected by complex humanitarian emergencies.

Current Activities

- Coordinates CDC's response to complex humanitarian emergencies; provides technical assistance to other Federal agencies, the United Nations, and other organizations in areas related to the health of refugee populations; applies epidemiological and public health principles to the study of complex emergencies; works with international partners to identify the number and nature of landmine-related injuries and deaths; provides technical assistance and training in public health emergency planning; and conducts training for constituents at CDC, educational institutions, and international organizations.
- Provided health, nutrition, water, and sanitation training for UNICEF regional staff, conducted in collaboration with Tufts University and Columbia University. Four of these Training for Improved Practice workshops have been held, training more than 100 UNICEF staff (principally health and nutrition professionals). This number accounts for approximately 15 percent of UNICEF's health and nutrition professionals.

Significant Accomplishments

- Measles Campaign in Liberia - The nationwide measles campaign in Liberia has to date successfully immunized 1.3 million children with coverage surveys estimating over 90 percent of children being vaccinated. On the basis of the number of children susceptible to measles prior to the campaign, an estimated 20,000 deaths among children less than five years of age have been averted by this campaign.

RATIONALE FOR THE BUDGET

The FY 2006 budget request of \$146,888,000 for Environmental Health represents decrease of \$596,000 below the FY 2005 Enacted level of \$147,484,000. This includes the restoration of an FY 2005 Labor/HHS/Education reduction of \$72,000.

IT REDUCTION

Funding for the Environmental Health activity includes an information technology savings of \$668,000.

OUTPUT TABLE

OUTPUT TABLE	FY 2004 ACTUAL	FY 2005 APPROPRIATION	FY 2006 ESTIMATE	FY 2006 +/- FY 2005
Chemicals included in the National Report on Human Exposure to Environmental Chemicals	149	150	180	30
New or improved methods developed for measuring environmental chemicals in people	16	16	16	0
Clinical laboratories certified for measuring Lipids, Newborn Screening, Blood Lead, and Urinary Iodine	653	653	653	0
EHHE Health Tracking Data (number of states)	0	5	5	0
State-based demonstration projects to define tracking functions for the National Environmental Public Health Tracking Network	0	13	17	4
EHHE Health Studies	27	25	25	0

NARRATIVE JUSTIFICATIONS
ENVIRONMENTAL HEALTH AND INJURY
ENVIRONMENTAL HEALTH

OUTPUT TABLE	FY 2004 ACTUAL	FY 2005 APPROPRIATION	FY 2006 ESTIMATE	FY 2006 +/- FY 2005
Laboratory studies conducted to measure levels of environmental chemicals in exposed populations	55	55	55	0
Funded state and local lead programs that develop and implement elimination plans	32	32	42	10
State, local, and territorial programs funded to develop or implement comprehensive asthma control programs	35	35	35	0
States with Web-based systems to track children's blood	10	10	10	0
States assisted with screening newborns for preventable diseases	50	50	50	0
Number of nations with surveillance systems to detect injuries and death related to landmines and unexploded ordinance	6	8	8	0
Professionals trained to provide public health services in complex humanitarian emergencies	627	1000	1000	0
Percentage of nations with unified and coordinated strategy for responding to international health emergencies	9	10	12	2
Percentage of chemical stockpiles that are disposed of without serious injuries or deaths from chemical agents	100	100	100	0
Percentage of agencies trained to improve their environmental health services programs	1.75	10	25	15
Percentage of agencies who have demonstrated improvement in the environmental health services program	10	20	30	10

FUNCTIONAL TABLE

Environmental Health Budget by Functional Activity (Dollars in Thousands)	FY 2004 Actual	FY 2005 Enacted	FY 2006 Estimate	FY 2006 +/- FY 2005
Environmental Health Laboratory	\$27,110	\$27,564	\$27,337	(\$227)
Environmental Health Activities	\$50,462	\$51,024	\$50,858	(\$166)
Asthma	\$32,101	\$32,422	\$32,317	(\$106)
Childhood Lead Poisoning	\$36,786	\$36,474	\$36,376	(\$97)
Total -	\$146,458	\$147,484	\$146,888	(\$596)

INJURY PREVENTION AND CONTROL

AUTHORIZING LEGISLATION

PHSA §§ 301, 307, 310, 311, 317, 319, 327, 391-394A; Sec. 413 of the Keeping Children and Families Safe Act (42 U.S.C. 10418).

Injury Prevention and Control (Dollars in Thousands)	FY 2004 Actual	FY 2005 Enacted	FY 2006 Estimate	FY 2006 +/- FY 2005
BA	\$136,467	\$138,237	\$137,931	(\$306)

STATEMENT OF THE BUDGET

The FY 2006 budget request of \$137,931,000 for Injury Prevention and Control represents a decrease of \$306,000 below the FY 2005 Enacted level of \$138,237,000.

PROGRAM DESCRIPTION

Injuries are the leading cause of death among children and adults under 44 years of age in the U.S. In 2002, more than 161,000 people died from injuries and violence, and nearly 30 million people sustained injuries serious enough to require treatment in an emergency department. Many injured people are left with long-term disabilities. The total lifetime costs associated with both fatal and nonfatal injuries is estimated to exceed \$260 billion.

CDC works to prevent premature death and disability and to reduce the human suffering and medical costs caused by injuries and violence. To prevent injuries and minimize their consequences when they occur, CDC uses the public health approach to define the injury problem, identify risk and protective factors, develop and test prevention strategies, and ensure the widespread adoption of effective strategies.

CDC funds public health research on injury prevention and control as outlined in the Injury Research Agenda. Focus areas include: injuries in the home and community; injuries in sports, recreation, and exercise; transportation injuries; intimate partner violence, sexual violence, and child maltreatment; suicidal behavior; youth violence; and acute care, disabilities, and rehabilitation.

Research identifies effective strategies to prevent injuries, strategies that must then be widely disseminated. CDC supports injury prevention programs at the state and local level and works to build injury prevention and control capacity. This is particularly important to protect vulnerable populations and improve outcomes for those who have been injured. A robust injury prevention infrastructure at the state and local level will help the dissemination and implementation of programs proven to prevent disability and death.

Funding for Injury Prevention & Control for the last five years:

FY	FUNDING*
2001	\$142,832,000
2002	\$149,502,000
2003	\$148,414,000
2004	\$136,467,000
2005	\$138,237,000

*FY 2004 and FY 2005 funding levels reflect the removal of management and administrative costs under the new budget structure. FY 2001-2003 funding levels are not available in the new structure and include management and administrative costs.

PERFORMANCE ANALYSIS

Injury comprises a fundamental threat to human health and life, and CDC employs the same scientific methods to prevent injuries as it uses to prevent infectious disease – defining the health problem, identifying risk and protective factors, and developing and testing prevention strategies. CDC works to ensure that proven techniques move from testing to widespread use, so that Americans at greatest risk of injury will be safer from harm.

GOAL: INCREASE THE CAPACITY OF INJURY PREVENTION AND CONTROL PROGRAMS TO ADDRESS THE PREVENTION OF INJURIES AND VIOLENCE.

Current Activities

- State Injury Prevention and Control Programs: CDC funds 28 states to build basic injury prevention programs. In addition, four states (Maine, Virginia, Michigan, and Washington) receive funding to develop the capacity of state health agencies to implement comprehensive and proven injury prevention programs. Michigan and Washington are developing targeted programs to address falls among older adults. Maine and Virginia are developing programs to prevent suicide.
- Rape Prevention and Education: CDC addresses rape prevention by supporting every state, Washington, D.C., Puerto Rico, and seven territories through the Rape Prevention and Education grant program. CDC provides resources and assistance to states and territories for rape prevention and education programs conducted by rape crisis centers, state sexual assault coalitions, and other public and private nonprofit entities. CDC assists state and coalition staff through training opportunities, support for the National Sexual Violence Resource Center, and research to learn what works in preventing rape.
- Intimate Partner Violence Prevention Programs: CDC also funds the Domestic Violence Prevention Enhancement and Leadership through Alliances (DELTA) program in 14 states. DELTA supports state domestic violence coalitions to provide prevention-focused technical assistance, training, and funding to local communities. In addition, CDC is funding projects for the prevention of sexual violence and intimate partner violence among racial and ethnic minority populations in order to support the development, implementation and evaluation of sexual violence and intimate partner violence prevention programs and services for minority populations.
- Preventing Child Abuse and Neglect:
 - Collaboratives are funded in three states (Georgia, Massachusetts, and Minnesota) to prevent the perpetration of child sexual abuse by focusing on adult and community responsibility for prevention. The collaboratives complement existing programs that focus on victim identification and services in order to build a comprehensive approach to child sexual abuse.
 - CDC funds three national organizations for the BECAUSE (Building and Enhancing Community Awareness United for Safety and Empowerment) Kids Count! Program to build or expand their capacity and the capacity of their state, local, and/or regional affiliates to address the prevention of child maltreatment, which includes physical abuse, emotional abuse, neglect, and sexual abuse.
 - CDC funds eight state health departments to apply public health approaches to the prevention of violence perpetrated toward or among children and adolescents so that it is raised as a public health priority within the state. This project focuses on identifying strategies at the individual, relationship, community, and societal levels that would reduce shared risk and enhance shared protective factors for violence affecting children and adolescents.
- Eliminating Residential Fire Deaths: CDC funds 16 states to continue smoke alarm installation and fire safety education programs in high-risk communities, where fire death rates are higher than state and national averages and median household incomes are below the poverty level.

Significant Accomplishments

- Documented the medical expenditures attributable to non-fatal injuries in the United States. CDC released an analysis of data on injury prevalence and costs from the 2000 Medical Expenditure Panel Survey and the National Health Accounts. Data indicated that injury-attributable medical expenditures cost as much as \$117 billion in 2000, approximately 10 percent of total U.S. medical expenditures.
- Prevented Residential Fire Deaths. A survey of homes participating in CDC-funded smoke alarm installation and fire safety education programs found that 663 lives have been saved to date. Program staff have canvassed almost 320,000 homes and installed more than 231,000 long-lasting or lithium-battery powered smoke alarms in high-risk homes, targeting households with children ages five years and younger and adults ages 65 years and older. Fire safety messages have reached millions of people as a result of these programs.

GOAL: MONITOR AND DETECT FATAL AND NON-FATAL INJURIES.

Current Activities

- National Violent Death Reporting System (NVDRS): CDC funds 17 states to implement the NVDRS and gather and share state-level data about violent deaths. This state-based system collects data from medical examiners, coroners, police, crime labs, and death certificates to understand the circumstances surrounding violent deaths. This information can be used to develop, inform, and evaluate violence prevention programs.
- Monitoring the Impact of Traumatic Brain Injury (TBI): CDC funds 11 states to determine the number of persons who die or seek hospital care due to a TBI and to document TBI-related disabilities. States use these data to develop programs to prevent TBI, educate the public about TBI, and identify the need of services for persons with TBI. A follow-up registry in one state (South Carolina) is funded to determine what happens to people and what kinds of services they need after hospitalization with a TBI.
- National Electronic Injury Surveillance System- All Injury Program (NEISS-AIP): The National Electronic Injury Surveillance System-All Injury Program (NEISS-AIP) is a national probability sample of hospitals with emergency departments in the U.S. and its territories. NEISS-AIP hospitals provide data from about 500,000 injury-related ED cases yearly. These data are utilized to calculate national estimates of all types and causes of nonfatal injuries treated in hospital EDs and are important for monitoring trends over time and for designing and evaluating national, state and community-based injury prevention programs. NEISS-AIP is collaboration between the U.S. Consumer Product Safety Commission and the National Center for Injury Prevention and Control, CDC. Data collected through NEISS-AIP is available through WISQARS™ (Web-based Injury Statistics Query and Reporting System), an interactive database system that provides customized reports of injury-related data. WISQARS can be accessed at <http://www.cdc.gov/ncipc/wisqars>.

Significant Accomplishments

- Published Traumatic Brain Injury in the United States: Emergency Department Visits, Hospitalizations, and Deaths. This report provides detailed information about traumatic brain injury (TBI)-related deaths, hospitalizations, and emergency department visits in the United States. The data can be used to address a wide range of important questions, such as how many TBIs occur each year in the United States, who is affected, and how these TBIs occur. This report is a reference for policy makers, service providers, educators, researchers, advocates, and others interested in knowing more about the impact of TBI in the United States.

GOAL: CONDUCT A TARGETED PROGRAM OF RESEARCH TO REDUCE INJURY-RELATED DEATH AND DISABILITY.

Current Activities

- Injury Control Research Centers: CDC's Injury research demonstrates what works to keep people safe. CDC funds 12 university-based Injury Control Research Centers throughout the U.S. to conduct research and provide state and community training and technical assistance. These research centers work to identify critical gaps in knowledge of injury risks and protection, particularly among vulnerable populations; conduct important research to address these gaps and disparities; and communicate their findings to community public health workers to shape effective programs that benefit all of us.
- Centers of Excellence on Youth Violence: CDC established ten National Academic Centers of Excellence on Youth Violence to foster joint efforts between university researchers and communities to address the problem of youth violence. The centers focus on developing and implementing community response plans, training health care professionals and conducting research projects to evaluate effective strategies for preventing youth violence.
- Extramural Research Grants Program: CDC supports a highly successful investigator-initiated, peer-reviewed grant program for academic research institutions across the country. In FY 2004, CDC received almost 300 applications for injury prevention and control research, and made 41 awards (13.8% success rate). Some of the crosscutting areas of research include biomechanics, trauma care research, violence prevention, home and recreational injuries, motor vehicle injuries, and disability prevention for injured persons. CDC also provides funds to new investigators in the field of injury and provides dissertation awards to graduate students to further develop the capacity of the injury research community. Small Business Innovation Research (SBIR) projects in injury prevention and control explore new technologies, such as ways to evacuate people in mass causality events and an alert for motor vehicle occupants exposed to dangerous carbon monoxide levels.

Significant Accomplishments

- **Improving the Quality of Mental Health Care after Trauma:** CDC extramural research evaluated and identified an independent association between of trauma survivors presenting with an elevated heart rate in acute care settings and subsequent development of posttraumatic stress disorder. Future investigations to better understand this relationship have the potential to improve the quality of mental health care delivered to injured survivors of trauma.
- **Preventing Violence and Crime in Small Businesses:** CDC-funded researchers evaluated the implementation of a customized robbery and violence prevention program in high-risk businesses. This project resulted in a significant decrease in overall violent crime and robbery for the businesses that had high compliance.
- **New Investigator Training Awards for Injury Prevention and Control Research:** CDC funds research to encourage professionals from a wide spectrum of disciplines and to support injury research by new investigators who have not previously received injury-related grants. Several previous recipients of New Investigator Awards have gone on to receive investigator-initiated, peer-reviewed grants from CDC and from other grant-making bodies.
- **Examining the Consequences of Nonfatal Fall-Related Traumatic Brain Injury (TBI) Among Older Adults:** A CDC-funded study found that nonfatal, hospitalized fall-related TBIs have significant consequences on the healthcare delivery system in California. For example, an estimated annual average of 3,000 elderly nonfatal falls result in hospitalizations for TBI costing approximately \$50 million. Researchers also found that for those over 85 years old, three out of every five hospitalizations resulted in a discharge to a residential facility with skilled nursing or to a home health service with outpatient rehabilitation services.

RATIONALE FOR THE BUDGET

The FY 2006 budget request of \$137,931,000 for Injury Prevention and Control represents a decrease of \$306,000 below the FY 2005 Enacted level of \$138,237,000. This includes the restoration of an FY 2005 Labor/HHS/Education reduction of \$69,000.

IT REDUCTION

Funding for the Injury Prevention and Control activity includes an information technology savings of \$375,000.

OUTPUT TABLE

OUTPUT TABLE	FY 2004 ACTUAL	FY 2005 APPROPRIATION	FY 2006 ESTIMATE	FY 2006 +/- FY 2005
Injury Prevention and Control Programs				
Core Injury Programs	28	30	30	0
Targeted State Injury Programs	4	4	4	0
Rape Prevention and Education	59	59	59	0
Intimate Partner Violence Prevention Programs	24	24	24	0
Child Maltreatment Prevention Activities	14	14	14	0
Residential Fire-Related Injury Prevention Programs	16	16	16	0
Injury Surveillance Systems				
National Violent Death Reporting System	17	17	17	0
Traumatic Brain Injury (TBI) Surveillance	11	11	11	0
National Electronic Injury Surveillance System – All Injury Program (NEISS-AIP)	1	1	1	0
Injury-Related Research				
Injury Control Research Centers	12	12	12	0

NARRATIVE JUSTIFICATIONS
ENVIRONMENTAL HEALTH AND INJURY
INJURY PREVENTION AND CONTROL

OUTPUT TABLE	FY 2004 ACTUAL	FY 2005 APPROPRIATION	FY 2006 ESTIMATE	FY 2006 +/- FY 2005
National Academic Centers of Excellence in Youth Violence	10	10	10	0
Research Grants to Individual Investigators for Injury Prevention	77	77	77	0

FUNCTIONAL TABLE

Injury Prevention & Control Budget by Functional Activity (Dollars in Thousands)	FY 2004 Actual	FY 2005 Enacted	FY 2006 Estimate	FY 2006 +/- FY 2005
Intentional Injury	\$101,733	\$103,138	\$102,814	(\$324)
Unintentional Injury	\$34,734	\$35,099	\$35,117	\$18
Total -	\$136,467	\$138,237	\$137,931	(\$306)

OCCUPATIONAL SAFETY AND HEALTH

AUTHORIZING LEGISLATION

PHSA §§ 301, 304, 306, 308, 310, 311, 317, 317A, 317B, 327; Occupational Safety and Health Act of 1970 (P.L. 91-596), §§ 20-22; Federal Mine Safety and Health Act of 1977, P.L. 92-173 as amended by P.L. 95-164, §§ 101, 102, 103, 202, 203, 204, 205, 206, 301, 501, 502, 508; Federal Fire Prevention and Control Act, § 209, (29 U.S.C. 671(a)); Radiation Exposure and Compensation Act, §§ 6 and 12 (42 U.S.C. 2210); Housing and Community Development Act of 1922 § 1021 (15 U.S.C. 2685); Floyd D. Spence National Defense Authorization Act §§ 3611, 3612, 3623, 3624, 3625, 3626 of P.L. 106-393.

Occupational Safety and Health (Dollars in Thousands)	FY 2004 Actual	FY 2005 Enacted	FY 2006 Estimate	FY 2006 +/- FY 2005
BA	\$241,307	\$198,970	\$198,859	(\$111)
PHS Evaluation Transfers	\$35,681	\$87,071	\$87,071	\$0
Total	\$276,988	\$286,041	\$285,930	(\$111)
FTE	1,287	1,244	1,246	2

STATEMENT OF THE BUDGET

The FY 2006 budget request of \$285,930,000 for Occupational Safety and Health represents a decrease of \$111,000 below the FY 2005 Enacted level of \$286,041,000.

PROGRAM DESCRIPTION

Around the world, millions of men and women work in poor and hazardous conditions. Each year, more than two million people die of work-related accidents and diseases, and more than 160 million workers fall ill due to workplace hazards. The mission of CDC is to provide national and world leadership to prevent work-related injuries and illnesses among workers. CDC conducts research to reduce work-related injuries and illnesses and promotes safe and healthy workplaces through interventions, recommendations and capacity building.

To address this enormous challenge, CDC introduced its most significant collaborative effort, the National Occupational Research Agenda (NORA) in 1996. NORA is a ten-year framework to guide occupational safety and health (OSH) research. NORA has resulted in a number of benefits to the OSH community, including:

- Concentrated efforts between government, academia, labor unions and industry that lead to faster, more effective implementation of OSH-related workplace solutions.
- Full integration of the CDC extramural research program into the National Institutes of Health (NIH) grants management system (known for its exemplary peer review standards and staffed by leading extramural scientists from the field of public health). CDC has created an environment that assures the quality and relevance of its extramural program. These efforts have resulted in the joint funding of high priority research grants with 14 NIH partner Institutes and the Environmental Protection Agency.

CDC has placed increased attention on the transfer and translation of research findings, technologies, and information into highly effective prevention services and products that are adopted in the workplace. Its goal is to reduce injury and illness by increasing the workplace use of effective, developed, and funded research findings. To achieve this, CDC continues to work with its partners to focus research on ways to develop effective products, to translate research findings into practice, to target dissemination efforts, and to evaluate and demonstrate the effectiveness of these efforts in improving worker safety and health.

Funding for Occupational Safety and Health for the last five years:

FY	FUNDING
2001	\$260,032,000
2002	\$275,808,000
2003	\$273,384,000
2004	\$276,988,000
2005	\$286,041,000

PERFORMANCE ANALYSIS

RESEARCH

CDC conducts research on the full scope of occupational illnesses and injuries: from basic research on mechanisms and etiology of occupational diseases, to applied research on specific ways to prevent illness and injury in the workplace. Research is conducted both intramurally and extramurally, through cooperative efforts with a wide range of federal and non-federal partners. These efforts have been largely facilitated through the establishment of NORA, and CDC has aggressively aligned its intramural and extramural programs within the NORA framework.

GOAL: CONDUCT RESEARCH TO REDUCE WORK-RELATED ILLNESSES AND INJURIES.

Current Activities

- Agriculture ranks among the most hazardous industries. CDC conducts a national program in agricultural safety and health that includes both intramural and extramural components ranging from studies to assess pesticide exposure among farm families to the development of technology designed to reduce injuries due to tractor rollovers. To further enhance these efforts in FY 2005, CDC will fund ten Agricultural Safety and Health Centers that are located throughout the nation to be responsive to issues unique to the different regions.
- In 2005, CDC continues to work with key construction safety and health partners to coordinate research, evaluate the effectiveness of interventions, and disseminate those that emerge as best practices. As part of its focus on the building and construction industry, CDC pursues both intramural and extramural research on construction fatalities.
- CDC is participating in an international effort to understand the health impact of nanotechnology and how to control potential occupational health effects. For 2005, CDC has designated an additional \$0.5 million for the expansion of the Nanotechnology Health and Safety Program, under NORA. This initiative will study the toxicity and health impact of a range of nanomaterials. The program will primarily focus on the role of surface area as an exposure metric, the toxicity and health effects associated with carbon nanotubes and other nanomaterials, and the nature and control of occupational diesel emissions. This effort is part of a government-wide program to ensure that the U.S. will remain a world leader in nanotechnology research and development.
- Motor vehicle-related incidents are consistently the leading cause of work-related fatalities in the U.S. In response, CDC initiated the multidisciplinary Occupational Motor Vehicle Safety and Health Research Program under NORA to address topics such as ambulance crash survivability, the influence of fatigue in truck drivers, and the risk factors for vehicle crashes among public employees. CDC also actively engages employers to promote motor vehicle safety by providing technical assistance and disseminating Hazard Alerts and Fact Sheets that present practical prevention strategies in both English and Spanish.

Significant Accomplishments

- Both the 2003 and 2004 Public Health Science Literary Awards were given to CDC publications on research in the area of control technology to reduce boat-related carbon-monoxide (CO) poisonings. This research was initiated in 2000 by CDC's identification of the serious, yet previously unrecognized, hazard of boat-related CO poisonings. Finding that 90% of recreational boats produce hazardous CO concentrations, CDC, in partnership with the U.S. Coast Guard and boat and engine manufacturers, worked to develop CO control technology for gasoline-powered boats. Subsequent evaluations revealed that vertical exhaust stacks are effective at controlling generator exhaust and preventing CO over-exposure. This ground-breaking research has resulted in numerous peer-reviewed publications, and a CDC-authored Coast Guard directive to

manufacturers on generator exhaust stack design. Two CDC scientists involved in this ongoing research initiative have been recognized, and were awarded the National Water Safety Congress' 2004 National Award.

- CDC continues to lead in the development of new occupational safety and health research methodologies. The CDC Manual of Analytical Methods provides a compilation of approximately 300 methods for measuring workplace exposures and toxic substances. The publication is widely used by universities, state and Federal agencies, analytical laboratories and businesses throughout the U.S. and in 25 countries abroad. In 2004, CDC published the third supplement to the Manual, presenting 39 new and 18 revised sampling and analytical methods for assessing potential hazards such as diesel exhaust, silica, and aerosols. Many of these methods were developed in response to CDC's Health Hazard Evaluations which identified hazardous exposures to chloramines, food flavoring additives and pesticides.
- Studies have associated workplace exposures to hazardous drugs with health effects such as skin rashes, infertility, and possibly leukemia and other cancers. In 2004, a CDC working group comprised of 50 representatives from government, labor, pharmacy, nursing, academia, and industry produced a CDC Alert on Hazardous Drug Exposure. This CDC Alert contains lists of drugs that should be handled as hazardous or with special precaution, and provides workers and employers with tools for preventing exposure. The guidance applies to over 5.5 million workers including health care providers, pharmacists, veterinarians, environmental services workers, and shipping and receiving personnel. In October 2004, CDC sponsored a workshop to discuss the Alert, which was followed by a Department of Veterans Affairs teleconference for health and safety managers (November 2004) and a presentation at the 39th Annual American Society of Health-System Pharmacists Midyear Clinical Meeting (December 2004). As a result of the Alert, CDC scientists are currently conducting studies on glove permeation and biological safety cabinet ventilation that will result in the development of new products and technologies to protect worker health.

INTERVENTIONS, RECOMMENDATIONS, AND CAPACITY BUILDING

CDC intervention and recommendation activities bring tools, techniques, information, and procedures into the workplace that are intended to improve the health and safety of workers. CDC's capacity building efforts are meant to develop the capabilities of individuals and agencies in the field of occupational safety and health. This is accomplished through training and disseminating current and applicable occupational safety and health information to industry, workers, governments, and scientific and professional communities, both nationally and internationally.

GOAL: PROMOTE SAFE AND HEALTHY WORKPLACES THROUGH INTERVENTIONS, RECOMMENDATIONS, AND CAPACITY BUILDING.

Current Activities

- CDC translates and disseminates research findings for the occupational safety and health community. In 2004, CDC established the Office of Science Policy and Technology Transfer to ensure that all occupational safety and health research funded by the agency (both intramural and extramural) is focused on the application of the research findings to prevent work related illness or injury. This is accomplished by facilitating partnerships throughout the entire research process so that findings are most amenable to implementation; bringing inventions to market; transferring knowledge and products to employers, workers, and policy makers; and evaluating programs for their impact. In FY 2005 and FY 2006, all research projects to be funded under NORA must be consistent with the research-to-practice principles.
- CDC responds to employer, employee, and state and local requests for worksite health hazard evaluations (about 400 each year). CDC assesses the workplace and health of employees by reviewing records and/or conducting on-site testing. These evaluations present the opportunity to obtain information on occupational exposures where standards are lacking, or do not protect all workers. After completion of the evaluations, CDC conducts follow-up surveys of participants to assess their satisfaction with the process and to learn whether the recommendations provided led to workplace improvements.
- CDC implements the *Steps to a HealthierUS Workforce* initiative to integrate occupational safety and health protection with health promotion activities in a coordinated system that addresses both workplace and worker health. In October 2004, CDC officially launched the Initiative by conducting a symposium with the support of 23 co-sponsors and over 400 participants. This initiative is the first of its kind to unite researchers, policymakers, practitioners, and industry and labor leaders in one place with the goal of developing mutually supportive strategies for research and practice to improve worker health, safety, and well-being.

- CDC provides workplace-related safety and health information to employers, workers, industry, academia, the occupational safety and health community, and the general public through its English and newly-implemented Spanish web sites.
- CDC increases workplace use of control and personal protective technology, particularly for emergency responders to chemical, biological, radiological, and nuclear (CBRN) terrorist events.

Significant Accomplishments

- Research & Development Award – CDC, in collaboration with manufacturers, labor, and industry, developed a new personal dust monitor (PDM) for assessing coal miners’ exposure to coal dust in underground coal mines. The first advancement in more than 30 years for monitoring exposures, the PDM was awarded a Research & Development 100 Award as one of the top 100 innovations of the year. The PDM provides real-time exposure data during a work shift so that mine operators can reduce over-exposures that might lead, over time, to the development of coal workers’ pneumoconiosis or “black lung,” a debilitating lung disease that caused 14,000 deaths between 1991 and 2000. CDC and the stakeholders will continue to test the PDM to verify its performance and discuss how the PDM may be implemented into the U.S. coal mining industry and abroad.
- Respirator Certification – CDC continues to conduct a respirator certification program to ensure respiratory protective equipment conforms to established regulatory performance and quality standards. In FY 2004 CDC approved 45 self-contained breathing apparatus (SCBA) and 2 air-purifying respirators for occupational use by emergency responders against CBRN agents. To enable responders to obtain CBRN protection without purchasing new equipment, CDC has initiated a CBRN SCBA retrofit certification program. Subsequently, 16 retrofit kits have been approved for use in upgrading existing SCBA to current performance standards. In addition, CDC has implemented a CBRN research and development test program to enable respirator manufacturers’ to test the effectiveness of their respirators against chemical warfare agents at a U.S. Army chemical test laboratory, prior to submission for certification.
- Health Hazard Evaluation – At a Midwestern poultry processing plant, employees in one department were coughing, sneezing, wheezing, and experiencing itchy and burning eyes. Working with the state occupational health agency, employer and employees, CDC linked the symptoms with exposures to airborne compounds called chloramines. Once the likely cause was identified, CDC proceeded with the same team of partners to develop, install, and evaluate changes in the ventilation system to reduce employees’ exposure to the contaminants. CDC’s involvement not only solved the immediate problem, but stimulated the development of new analytical methods for better measurement of chloramines – an elusive occupational hazard.

RATIONALE FOR THE BUDGET

The FY 2006 budget request of \$285,930,000 for Occupational Safety and Health represents a decrease of \$111,000 below the FY 2005 Enacted level of \$286,041,000. This includes the restoration of an FY 2005 Labor/HHS/Education reduction of \$99,000.

IT REDUCTION

Funding for the Occupational Safety and Health activity includes an information technology savings of \$210,000.

OUTPUT TABLE

OUTPUT TABLE	FY 2004 ACTUAL	FY 2005 APPROPRIATION	FY 2006 ESTIMATE	FY 2006 +/- FY 2005
NORA Intramural Research Projects	262	264	264	0
Safety and Health Patent Filings	6	5	5	0
Certification Decisions Issued for Personal Protective Devices and Industrial Hygiene Instruments Evaluated for Certification	450	450	450	0
Estimated Academic Graduates	500	550	550	0
Estimated Continuing Education Trainees	30,000	35,000	35,000	0

NARRATIVE JUSTIFICATIONS
OCCUPATIONAL SAFETY AND HEALTH

OUTPUT TABLE	FY 2004 ACTUAL	FY 2005 APPROPRIATION	FY 2006 ESTIMATE	FY 2006 +/- FY 2005
Hazard Evaluations/ Fatality Assessment and Control Evaluations	649	665	665	0
Number of Research Articles Published in Peer-Review Publications	234	200	200	0
Agricultural Centers	10	10	10	0
Number of States Receiving Public Assistance	35	35	35	0
Research Grants	199	205	205	0
Training Grants	57	60	60	0
CDC NIOSH Web site Visitors Sessions	5.0M	6.0M	6.0M	0
Responses to 1-800-356-4674 CDC NIOSH calls for Technical Information on Occupational Safety and Health Issues	140,000	140,000	140,000	0

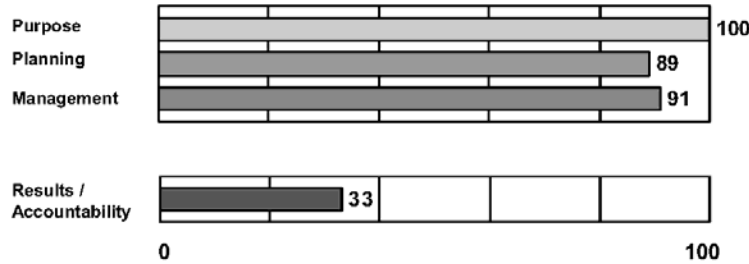
FUNCTIONAL TABLE

Occupational Safety & Health Budget by Functional Activity (Dollars in Thousands)	FY 2004 Actual	FY 2005 Enacted	FY 2006 Estimate	FY 2006 +/- FY 2005
Education and Research Centers	\$16,051	\$17,402	\$17,411	\$9
National Personal Protective Technologies Lab	\$10,185	\$11,487	\$11,492	\$6
National Occupational Research Agenda (NORA)	\$81,600	\$87,071	\$87,071	\$0
Mining Research Program	\$27,717	\$31,704	\$31,719	\$16
All Other Occupational Safety Activities	\$83,445	\$80,388	\$80,247	(\$141)
Management and Administrative Costs	\$57,990	\$57,990	\$57,990	\$0
Total -	\$276,988	\$286,041	\$285,930	(\$111)

Program: CDC: Occupational Safety and Health

Agency: Department of Health and Human Services

Bureau: Centers for Disease Control and Prevention



Key Performance Measures from Latest PART

	Year	Target	Actual
Long-term Measure: Reduce occupational illness and injury as measured by: a) percent reductions in respirable coal dust overexposure; b) percent reduction in fatalities and injuries in roadway construction, and c) percent of firefighters and first responders with access to chemical, biological, radiological, and nuclear respirators	2014	50/40/75	
	2003		>15/154/>7
Long-term Measure: Progress in targeting new research to the areas of occupational safety and health most relevant to future improvements in workplace protection, as judged by independent panels of external customers, stakeholders and experts.	2009	>95%	
	2004		0
Long-term Measure: The percentage of companies employing those with NIOSH training that rank the value added to the organization as good or excellent and the percentage of professionals with academic or continuing education training.	2009	80%, +15 %	

Rating: Adequate

Program Type: Research and Development

Program Summary:

The National Institute for Occupational Safety and Health (NIOSH) at the Centers for Disease Control and Prevention (CDC) is the lead Federal agency for research on the occupational health of US workers. The program conducts and supports research, responds to requests for investigation into workplace injuries, supports training and disseminates findings to inform worker safety programs and regulations.

The assessment found NIOSH has a clear purpose and is well managed overall, but has lacked strong performance measures and targeted evaluations to track its impact on reducing workplace illness and injuries. Details from the assessment include:

- NIOSH has a well established mechanism for setting priorities to guide budget requests and funding decisions through the National Occupational Research Agenda (NORA). Starting with a base of \$15 million in 1996, NIOSH has targeted an increasing amount of its research investments through NORA. This year, NIOSH will invest up to \$99 million through NORA's 21 priority areas of research.
- The program is working to further focus its research efforts on having an impact through a Research to Practice initiative.
- While reports from the Government Accountability Office that touch on the program's activities have suggested positive program performance, NIOSH lacks a recent, comprehensive evaluation.
- Through the assessment process NIOSH adopted new long-term measures that will help better capture the outcome of the program on occupational safety, illness and death.

In response to these findings:

1. The program will begin tracking performance on the percent of firefighters and first responders with access to chemical, biological, radiological, and nuclear respirators, the percent reductions in respirable coal dust overexposure, and the percent reduction in fatalities and injuries in roadway construction.
2. NIOSH will advance its work with the National Academy of Sciences to develop a standard method of measuring the impact of their research on the occupational safety and health field. The Academy will also rate NIOSH activities on progress in reducing workplace illness and injuries.
3. NIOSH will use performance information from its research efforts to help improve program direction, allocate resources and develop annual budgets.

Program Funding Level (in millions of dollars)

<u>2004 Actual</u>	<u>2005 Estimate</u>	<u>2006 Estimate</u>
277	286	286

PART RECOMMENDATIONS

The Occupational Safety and Health program was evaluated by PART during the FY 2006 budget cycle. Their follow-up actions are covered by the CDC-wide PART Recommendations below.

RECOMMENDATION	COMPLETION DATE	ON TRACK? (Y/N)	
Explicitly tie budget requests to the accomplishment of annual and long-term goals, and present resource needs in a complete and transparent manner.	On-going	Y	
COMMENT ON STATUS			
<p>CDC developed and piloted a marginal cost methodology in conjunction with HHS. During the HHS Budget and Performance Training Day on October 22, 2004, CDC explained the criteria for program selection and current marginal cost activities. CDC is now coordinating with HHS to complete the report for the TB pilot. The marginal cost methodology and pilot results will be distributed once the TB Prevention Marginal Cost Report is complete.</p> <p>This FY 2006 Congressional Justification is CDC's first submission to Congress combining budget and performance information into one document. The integrated "Performance Budget" more closely links GPRA goals with budget requests and full cost estimates.</p> <p>Members of the Goals Management Team presented written and oral reports to CDC's Executive Leadership Board (ELB) on December 7, 2004. These reports provided ELB members with findings and recommendations from the Goals Management pilot teams (Adolescents, Adults, and Preparedness Teams). Components of these reports included:</p> <ul style="list-style-type: none"> • Team Reports (from each of the three pilot teams) • Application of Complex Systems – Infant Mortality • Addressing Health Equity in Goals Management • 2004 Budget Allocation by Life Stage • A Comprehensive Plan for Change Management <p>The findings and recommendations from these reports will assist CDC as it moves forward with its Goals Management process.</p>			
NEXT MILESTONE	NEXT MILESTONE DATE	LEAD ORGANIZATION	LEAD OFFICIAL
Disseminate marginal cost methodology developed from the two pilots to all HHS OPDIV/STAFFDIV performance and budget officers. Hold a workshop for FDA and CDC to present the marginal cost methodology to the OPDIVs/STAFFDIVs.	03/31/05	CDC	Karen Long

RECOMMENDATION	COMPLETION DATE	ON TRACK? (Y/N)	
Use strong financial management practices.	4/30/05	Y	
COMMENT ON STATUS			
<p>CDC has made significant progress with its Unified Financial Management System (UFMS) implementation. Specific activities and accomplishments include:</p> <ul style="list-style-type: none"> • Phase 1 and 2 "Go Live" – With the successful completion of phases 1 and 2, the General Ledger, Accounting For Pay System (AFPS), and Grants Processing modules are in place. General ledger includes CDC's overall accounting "books." Implementation of AFPS aligns CDC's method of payroll accounting with a department-wide standardized process. With grants processing, CDC will process two critical business functions – representing over 55 percent of its dollars and transactions – in UFMS. • Travel Order and Voucher Submissions – Under new travel processes, the financial system will not accept travel vouchers that exceed the travel order amount by more than 10% or \$100, whichever is less. • Training Vendor Identification and Payment Processing – Training request submissions for which payment is to be made by training order require that the vendor be identified and selected in the Training System vendor file. Training requests for \$2,500 or less should be paid by credit card or convenience check whenever possible. • Use of Miscellaneous Obligations Documents (6012s) – CDC now accepts 6012s only for specific items and events. Further, the budget branch must approve the 6012 before the accounting branch will obligate any funds. • Automation of Local Travel Processing – Local travelers now complete, edit, and submit claims for mileage, parking, MARTA, and local transportation expenses through an automated system. The system provides the ability to review, assign, audit, or reject travel vouchers. • Retirement of Small Purchases and Procurement System (SPPS) – SPPS will be retired for FY 2005. ICE and Visa IMPAC will be used in its place. 			
NEXT MILESTONE	NEXT MILESTONE DATE	LEAD ORGANIZATION	LEAD OFFICIAL
Implement the full suite of Oracle/UFMS modules (Accounts Payable, Accounts Receivable, Purchasing, Budget Execution, Project Accounting).	4/30/05	CDC	Karen Long

GLOBAL HEALTH

AUTHORIZING LEGISLATION

PHSA §§ 301, 304, 307, 310, 319, 327, 340C, 2315, 2341; International authorities: P.L. 107-116 sec. 215.

Global Health (Dollars in Thousands)	FY 2004 Actual	FY 2005 Enacted	FY 2006 Estimate	FY 2006 +/- FY 2005
BA¹	\$285,983	\$293,863	\$306,079	\$12,216
FTE	95	92	92	0

¹Funding levels for FY 2004 are shown on a comparable basis. A total of \$148.992 million was removed from FY 2004 to reflect the transfer of the President's International Mother and Child HIV Prevention Initiative (PMTCT) from CDC to the Department of State Office of the Global AIDS Coordinator.

STATEMENT OF THE BUDGET

The FY 2006 budget request of \$306,079,000 for Global Health represents an increase of \$12,216,000 over the FY 2005 Enacted level of \$293,863,000.

PROGRAM DESCRIPTION

CDC's global programs are an essential component of promoting health and preventing disease in the United States and abroad, including ensuring rapid detection and response to emerging health threats. CDC coordinates, cooperates, participates with, and provides consultation to other nations, U.S. agencies, and international organizations to prevent and contain diseases and environmental health problems and to develop and apply health promotion activities. In cooperation with Ministries of Health and other appropriate institutions, CDC assesses evolving global health issues and identifies and develops activities to apply CDC's technical expertise to be of maximum public health benefit.

Included in the summary below are descriptions of the Global AIDS Program, the Global Immunization Program, CDC's Global Disease Detection Initiative, the Global Malaria Program, and a brief outline of other major Global Health activities at CDC. Funding for the programs outlined below is contained within the Global Health budget activity, and these programs offer an illustration of the breadth and depth of international programs at CDC. This narrative in no way represents the full gamut of international activities that CDC is engaged in around the world. There are numerous other public health efforts across CDC that compliment and strengthen CDC's domestic public health efforts. Descriptions of these additional programs are included throughout CDC's Congressional Justification.

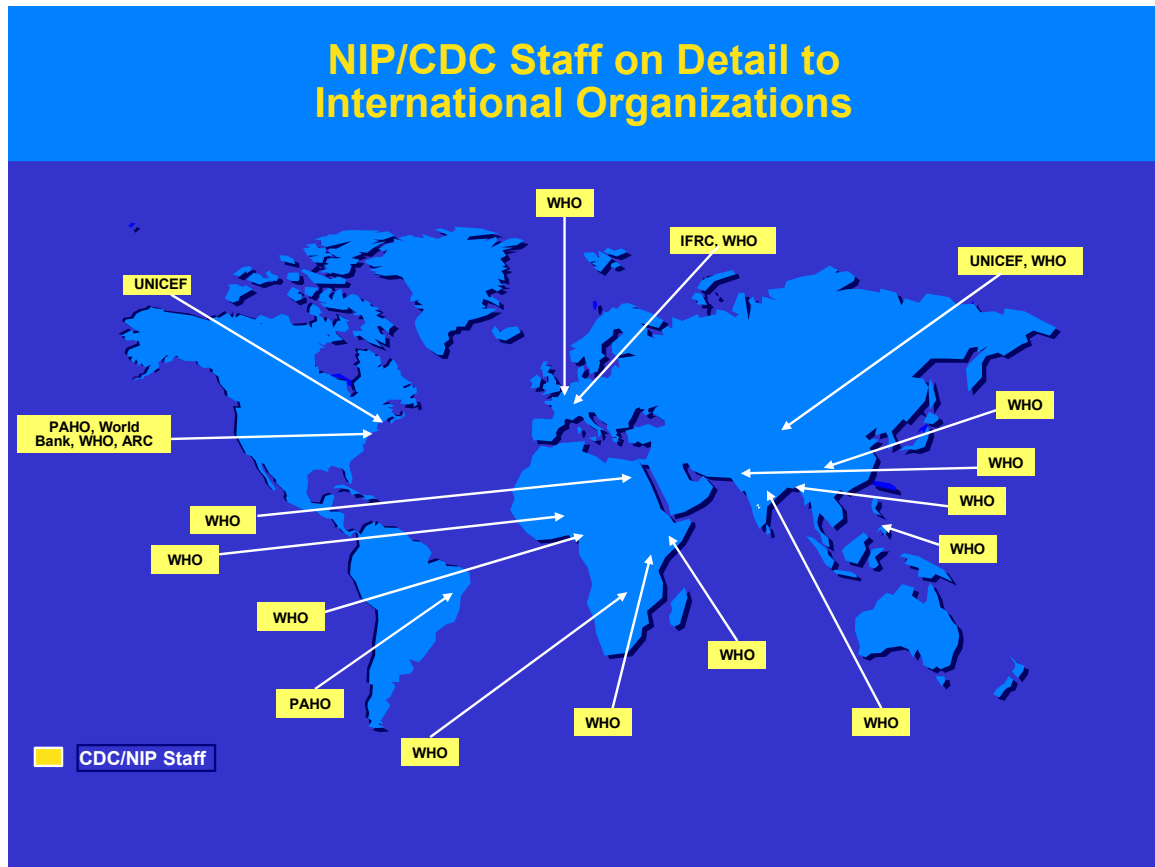
GLOBAL AIDS PROGRAM

Since 2000, the Global AIDS Program (GAP) has helped resource-constrained countries in Africa, Asia, Latin America and the Caribbean prevent HIV infection; improve treatment, care, and support for people living with HIV; and build capacity and infrastructure to address the global HIV/AIDS pandemic. In his 2003 State of the Union address, President Bush announced his intent to launch a comprehensive strategy for AIDS relief. In response, GAP joined other HHS agencies and other US Government (USG) departments to implement the President's Emergency Plan for AIDS Relief (the "Emergency Plan"), under the coordination of the Office of the Global AIDS Coordinator (OGAC) in the Department of State. GAP has 25 country programs (including the 15 focus countries) and four regional offices and works to mitigate the devastating effects of HIV/AIDS around the world by collaborating with diverse partners, including host country governments, other international health organizations, nongovernmental organizations, and universities. As part of the coordinated USG effort, GAP works to scale up programs with local sustainability; maintain a focus on prevention in the face of a new emphasis on treatment; provide high-quality public health programs while scaling up rapidly; and, address needs in non-focus countries.

GLOBAL IMMUNIZATION PROGRAM

CDC supports global immunization initiatives to protect American children from vaccine-preventable diseases imported into the United States or acquired abroad; to protect against the medical costs of morbidity and mortality associated with vaccine-preventable diseases; and for humanitarian reasons. CDC priorities in FY 2006 are global polio eradication, measles mortality reduction and regional measles elimination, and strengthening childhood immunization programs in developing countries. CDC supports these initiatives by providing epidemiologic, laboratory, and programmatic support to the World Health Organization (WHO) and UNICEF, by buying vaccine (through UNICEF), by assigning expert staff overseas (see map below) to help implement global immunization

programs, and providing short-term technical assistance abroad through temporary assignments of CDC experts from Atlanta. CDC operates in partnership with public and private sector partners to achieve global immunization objectives including Rotary International, American Red Cross, United Nations Foundation, International Federation of Red Cross and Red Crescent Societies, Bill and Melinda Gates Foundation, WHO, UNICEF, and World Bank.



GLOBAL DISEASE DETECTION

As demonstrated with the SARS outbreak, a highly pathogenic infectious disease in a remote region of the world can spread around the world in a matter of days and weeks. The goal of the Global Disease Detection initiative is to develop national and regional capacity to better detect and respond to infectious disease outbreaks of potential international importance, whether the cause is an intentional act of terrorism or the natural emergence of a deadly infectious pathogen, before they spread to other nations and the United States. Key to this effort is the development of disease detection and response platforms, a connected and secure information technology infrastructure, and pandemic influenza preparedness and response. In early FY 2005, CDC held two important consultations with technical experts and the corporate sector to assist in the development of clear priorities and strategies for the future. CDC is also increasing global connectivity to ensure rapid detection and response to emerging health threats with a focus on strategic regional/country platforms and information technology. Having CDC staff on the ground was invaluable in providing initial response support for the December 2004 Tsunami, particularly in Thailand.

GLOBAL MALARIA PROGRAM

Globally, malaria transmission occurs in more than 90 countries. Malaria was declared eradicated in the U.S. in the late 1950s, but up to 2,000 people in the U.S. get malaria each year from travel to malaria infected places. Each year more than 20 million U.S. travelers must use malaria prevention medicines, and an estimated 50,000 U.S. blood donors are rejected because of concern about malaria transmission via the blood supply. In endemic countries, malaria kills a child every 30 seconds, causes more than one million deaths and 500 million infections each year, is increasingly resistant to available medicines for treatment and to prevent infection in travelers, and gross domestic product is up to 20 percent lower than it would have been if there was no malaria during the last 15 years. Malaria, along with AIDS and TB, is a destabilizing factor and continues to pose a critical threat to the national security of all sub-Saharan African countries, and the U.S. is committed to helping their governments address this crisis.

CDC supports prevention and control of malaria throughout the world in partnership with local, state, and Federal agencies in the United States; medical and public health professionals; national and international organizations; and foreign governments by:

- Conducting malaria surveillance, prevention, and control activities in the United States;
- Conducting multidisciplinary research in the United States and internationally, in the laboratory and in the field, to develop new tools and improve existing interventions against malaria worldwide;
- Translating research findings into appropriate policies and effective practices;
- Providing consultation, technical assistance, and training as requested by outside agencies and malaria-endemic governments.

OTHER GLOBAL HEALTH

CDC is also the focal point for the provision of an extensive range of support services to other international activities.

FIELD EPIDEMIOLOGY & LABORATORY TRAINING PROGRAM (FELTP)

For the last two decades, CDC has recognized the critical need to collaborate with Ministries of Health around the world to develop specialists to implement surveillance and intervention programs with a focus on epidemiology, laboratory and management. The Field Epidemiology Training program primarily focuses on the development of technical staff. Through locally adapted training and field work, the graduates become expert in epidemiology. Most recently, the program has been expanded to include the linkage with the laboratory components. As shown during the tsunami disaster, the development of this local capacity can play a critical role in the ability of a country to mount an effective initial response. In the area of developing future public health leaders, CDC develops a pool of individuals trained in managerial and educational skills that will in turn, train others in their own country.

SUSTAINABLE MANAGEMENT DEVELOPMENT PROGRAM

The Sustainable Management Development Program (SMDP) strategy includes working with international donor partners to provide technical assistance to public health professionals as they establish in-country management training programs. Technical assistance focuses on 1) needs assessment; 2) curriculum development; 3) marketing, organizing, and teaching workshops; and 4) supervising applied learning projects.

Funding for Global Health for the last five years:

FY	FUNDING*
2001	N/A
2002	N/A
2003	N/A
2004	\$434,975,000
2005	\$293,863,000

*This budget activity has been created as part of CDC's new budget structure; therefore, funding levels are not available for FY 2001 – FY 2003.

PERFORMANCE ANALYSIS

GLOBAL AIDS PROGRAM

GOALS

- By 2010, work with other countries, international organizations, the Department of State, USAID and other partners to achieve the United Nations General Assembly Special Session on HIV/AIDS goal of reducing prevalence among persons 15 to 24 years of age. Since GAP is now working with other USG agencies on the Emergency Plan, CDC will retire this goal after the data are reported for FY 2005.
- Counsel, test, and treat up to one million pregnant women and reduce mother to child transmission by up to 40 percent among women treated, in collaboration with other parts of HHS and USAID. Note: In FY 2005, funding for the Emergency Plan and the President's Mother to Child HIV Prevention Initiative (PMTCT) is included in the Department of State's budget request and CDC will cease to report progress on Goal 2.

Current Activities

- Working closely with the Office of Global Health Affairs / HHS, OGAC / Department of State and other agencies to implement the Emergency Plan.
- Supporting bi-lateral programs in 25 countries and four regional offices around the world. Activities are concentrated on the prevention of new infections; care and treatment for those already infected; and surveillance and capacity-building to support effective programs that work in coordination with host-country priorities. CDC receives substantial additional funding transferred from the State Department to support expanded activities in the fifteen focus countries.

Significant Accomplishments

- Provided technical assistance and support for programmatic activities (e.g., laboratory capacity, surveillance, prevention, PMTCT), care and treatment for 25 GAP countries and 27 other countries served by regional offices.
- Assigned over 100 CDC staff to the field and employed over 1,000 local staff to implement country programs.
- Conducted almost two million HIV lab tests and almost 275,000 TB diagnostic tests overall in GAP-supported laboratories in FY 2004.
- Implemented more than 160 cooperative and interagency agreements with U.S. governmental and non-governmental agencies, U.S.-based universities and colleges, in-country governmental and non-governmental organizations, and international organizations to rapidly implement in-country programs.
- Served on the USG interagency teams that developed and reviewed the focus country operational plans for coordinated HIV/AIDS prevention, treatment, and care services.
- Contributed to the overall USG Emergency Plan efforts of directly supporting antiretroviral treatment (ART) for about 18,800 patients in nine focus countries as of July 31, 2004.
- Contributed to the overall USG Emergency Plan efforts of providing PMTCT services for 378,000 pregnant women from October 1, 2002 through March 31, 2004 in 14 focus countries. To date 34,000 HIV-positive women received short-course antiretroviral (ARV) prophylaxis in a PMTCT setting. The provision of short-course antiretroviral prophylaxis for 34,000 HIV-positive pregnant women resulted in an estimated 4,800 infant infections being averted.
- Provided counseling and testing to about 300,000 individuals and PMTCT services to over 550,000 pregnant women who reside in the ten non-focus countries in FY 2004.

GLOBAL IMMUNIZATION PROGRAM

GOALS

- Help domestic and international partners achieve World Health Assembly's goal of global polio eradication.
- Work with global partners to reduce the cumulative global measles-related mortality rate and achieve regional measles elimination goals.

Current Activities:

CDC's immunization efforts reach beyond the U.S. and encompass global strategies focused primarily on two diseases: polio and measles. CDC has become more actively involved in other global efforts, such as the Global Alliance for Vaccines and Immunization (GAVI), which seeks to introduce newer vaccines and establish routine immunization programs in developing countries. Global activities include:

- Providing funds through the United Nations Children's Fund (UNICEF) for the purchase of polio and measles vaccines.
- Providing technical assistance to WHO and UNICEF in countries in which polio and measles are endemic.
- Recruiting and training health professionals with experience in epidemiology and surveillance for Stop Transmission of Polio (STOP) teams. STOP activities have expanded to include work in measles surveillance and integrated disease surveillance data management.
- Providing assistance in conducting National Immunization Days.

- Conducting surveillance to aid polio eradication and to certify the eradication of polio, to monitor and direct global measles mortality reduction efforts, and to strengthen surveillance systems for other diseases.
- Collaborating with international organizations such as Rotary International, the International Federation of Red Cross and Red Crescent Societies, and the Pan American Health Organization.
- Assisting the WHO in building global polio and measles laboratory networks and helping build the platform for detection of other diseases.

Significant Accomplishments

- Since the global polio initiative began in 1988, an estimated 250,000 lives have been saved and five million cases of childhood paralysis prevented. Additionally, the number of polio cases has been reduced from more than 350,000 annually in 1988 to 784 cases reported in 2003, a decline of more than 99%. Today, more than 200 countries and territories are polio free and the disease is now indigenous to only six countries in the world: Nigeria, India, Pakistan, Niger, Afghanistan and Egypt. However, a polio outbreak in Nigeria in 2003-2004 has spread poliovirus from Nigeria to 12 previously polio-free countries of west and central Africa.
- Measles is no longer endemic in the U.S. A 2000 study by the CDC estimated that measles immunization in the U.S. prevents more than 3.4 million measles cases and 2,794 measles deaths, as well as saving \$7 billion in direct and indirect health care costs each year.
- The number of measles cases in the Western Hemisphere has been reduced by more than 99 percent from approximately 250,000 in 1990 to 101 (all associated with imported viruses) provisionally reported in 2004. Before measles vaccine was available, nearly everyone in the U.S. got the disease, resulting in approximately three to four million measles cases each year. An average of 450 measles-associated deaths was reported annually between 1953 and 1963.
- A goal to reduce annual measles mortality in Africa by 50% by the end of 2005 compared with 1999 WHO estimates is on target for achievement and will prevent more than 400,000 deaths from measles in 2005 alone.

GLOBAL DISEASE DETECTION

Current Activities

- Enhancing a comprehensive global surveillance and response network for infectious diseases by adding two new International Emerging Infections Program (IEIP) sites (total of six) that are strategically placed to integrate disease surveillance, applied research, and prevention and control activities in developing countries.
- Creating a network of FELTPs by supporting two new sites in China and Kenya, providing additional support for the epidemiology training at two current Field Epidemiology Training Program (FETP) sites in Brazil and India, and providing additional support for laboratory and management training at six current FETP sites (Brazil, Central America, Central Asia, Ghana, Uganda, and Zimbabwe).
- Enhancing the capability of WHO's Global Outbreak Alert and Response Network (GOARN) to monitor infectious disease events globally and respond as necessary to limit their spread.
- Beginning the implementation of an international e-CDC to link CDC with governments and corporations abroad to improve information sharing and communications about disease outbreaks.
- Targeting efforts to improve surveillance and pandemic preparedness for H5N1 avian influenza in Asia through: (1) bilateral support to foreign Ministries of Health (MOH) to build influenza surveillance networks to expand the capacity to identify influenza viruses including those with pandemic potential, (2) providing technical assistance and training, and (3) developing infrastructure upon which research leading to vaccine policy, vaccine production and better pandemic preparedness can be built.

Significant Accomplishments

- Established two International Emerging Infections Programs (Thailand, Kenya) that integrate disease surveillance, applied research, and prevention and control.
- Assessed ten CDC field sites information technology capacity for the development of a reliable and secure communications network among CDC and its global partners.

- Provided technical assistance in the areas of laboratory training, sustainable management training, distance learning and enhanced the national influenza surveillance programs in at-risk countries, formally linking them with the WHO global flu surveillance network.
- Conducted avian influenza transmission studies to better understand factors leading to emergence, allowing for earlier detection.

GLOBAL MALARIA PROGRAM

GOAL

- Provide technical leadership working with other countries, international organizations, the Department of State, USAID, and other partners, to achieve the Roll Back Malaria goal to halve the global burden of malaria by 2010

Current Activities

- Developing new prevention and treatment guidelines for US clinicians.
- Providing technical assistance to WHO; the World Bank; UNICEF; and malaria endemic countries in Africa, Asia, and the Americas in support of the global Roll Back Malaria program.
- Providing financial support to a consortium of universities to develop novel antimalarial drugs to address the growing problem of drug resistant malaria.
- Continuing current research studies on vaccine development, improved insecticide treated bednets, preventive intermittent treatment for infants, the impact of artemisinin-containing combination drug regimens, and mosquito larval ecology for the reduction of vector breeding.
- Evaluating national implementation of combined infant immunization and insecticide treated bednet delivery in Togo, Malawi, and other countries as needed.
- Collaborating with Liverpool School of Tropical Medicine, the Malaria Research and Training Center in Mali, the Malaria Research Center in India, and other institutions to strengthen international collaborative efforts to identify, evaluate, and implement malaria control strategies in sub-Saharan Africa and Asia.

Significant Accomplishments

- Collaborated with Roll Back Malaria partners on the development of the African Strategic Framework for Malaria Prevention in Pregnancy
- Provided financial support and/or technical assistance for research, policy development, and program implementation in Kenya, Tanzania, Uganda, Democratic Republic of Congo, Malawi, Mozambique, Eritrea, Mali, Madagascar, Zambia, Nigeria, Ghana, Rwanda, Benin, and seven regional networks.
- Completed data collection in Tanzania for a comprehensive evaluation of the impact of artemisinin containing combination anti-malarial therapy. Analysis and publication of results is beginning.
- Collaborated with international experts to write a review of strategies to improve health worker performance and with Roll Back Malaria and the WHO Child Health Epidemiology Reference Group on developing estimates for malaria-specific mortality for young children in Africa.
- Funded final year of four-year extramural support program for five schools of public health and three non-governmental organizations to support Roll Back Malaria program implementation and operations research in seven sub-Saharan African countries.

OTHER GLOBAL HEALTH ACTIVITIES

Significant Accomplishments

- Successfully concluded staffing plans based on CDC and DHHS priorities for CDC's regional/country platforms in Thailand, Kenya, and China. These plans focused on meeting the human resource and technical requirements necessary for combating newly emerging infectious diseases and on going programs, such as addressing the global HIV/AIDS problem. CDC also made projections for additional sites in Brazil, Central America, Central Asia, and the India.

- CDC awarded assessment contracts to improve its connectivity among all the CDC offices worldwide and it has worked directly with the Department of State and proactively advised DHHS on matters related to costs associated with the State Department's new Capital Security Cost Sharing initiative.
- CDC's action to track HHS personnel and contractors abroad will save DHHS and CDC significant funds in FY 2005 and future years.
- CDC, through its Global Health activities, also provides support services (passports, visa services, country notification, etc.) for CDC personnel in programs that conduct international programming.

FIELD EPIDEMIOLOGY & LABORATORY TRAINING PROGRAM (FELTP)

Current Activities

- CDC collaborates with Ministries of Health around the world to develop FELTPs for specialists in epidemiology and laboratory methods. FELTP is a two-year training and service program designed for health professionals in entry- or mid-level positions. These international professionals learn to address complex public health issues quickly and efficiently and develop leadership and applied epidemiology and laboratory skills.
- More than 95 percent of FELTP graduates still work in public health, creating and implementing surveillance and intervention programs.

Significant Accomplishments

- CDC provided consultation and support for approximately 29 FELTPs and FELTPs in various countries around the world. These programs have graduated 1,262 professionals since 1980.
- In addition, CDC provided technical and resource support to establish several new programs linking epidemiology and laboratory training and institutional support for the Training Programs in Epidemiology and Public Health Interventions Network (TEPHINET).
- For the tsunami disaster, FELTP graduates and trainees from impacted and neighboring countries were rapidly deployed during the initial response phase.

SUSTAINABLE MANAGEMENT DEVELOPMENT PROGRAM (SMDP)

Current Activities

- CDC conducts a six-week Management for International Public Health (MIPH) course through the SMDP for management trainers from developing countries in the basic management skills of planning, priority setting, problem solving, budgeting, and supervision. The course applies these management concepts to public health problems and provides tips, practical aids, and tools which facilitate teaching the materials to others.

Significant Accomplishments

- CDC has trained 264 trainers from 58 countries around the world through the SMDP. The graduates have returned home to teach these skills in a variety of public health settings including academic institutions, government training programs, and non-governmental organizations. Their instruction has benefited such public health areas as HIV/AIDS, TB, immunizations and malaria control. All local participants are required to complete an applied management project that applies classroom knowledge to real public health management problems in the workplace.
- CDC's second biennial conference on "Strengthening Global Public Health Management Training Capacity" was held in Hanoi, Vietnam, March 8-13, 2004. Co-sponsors were the Hanoi School of Public Health, Vietnam's National Hospital for TB and Respiratory Diseases and CDC. The conference, which attracted 150 participants from 23 countries, featured 30 presentations on public health management capacity-building by SMDP program graduates. Other sessions focused on the significance of sustainable management in public health, infrastructure assessment and sustainability, participant learning styles, and a summary of best practices in management capacity building programs.
- In April 2004, 33 participants from Guam Memorial Hospital graduated from a 5-month management training program planned and co-taught by two MIPH graduates from the University of Guam (UoG). This training was carried out under the UoG project entitled Health Leaders Achieving Today, Tomorrow's Excellence. The project is supported by a grant from CDC through a cooperative agreement with the Association of Teachers of Preventive Medicine (ATPM). The grant is designed to help the University strengthen public health management training capacity to meet local and regional needs in the Pacific. Other CDC-supported

management training programs are active in Botswana, Croatia, Guam, Malawi, Mexico, Nicaragua, the Philippines, Uganda, Vietnam, and Zambia.

RATIONALE FOR THE BUDGET

The FY 2006 budget request of \$306,079,000 for Global Health represents an increase of \$12,216,000 over the FY 2005 Enacted level of \$293,863,000. This includes the restoration of an FY 2005 Labor/HHS/Education reduction of \$138,000.

GLOBAL DISEASE DETECTION (+\$12,078,000)

The FY 2006 budget requests \$33.5 million, a \$12 million increase, for CDC's global disease detection initiative. This initiative aims to recognize infectious disease outbreaks faster, improve the ability to control and prevent outbreaks, and to detect emerging microbial threats. CDC will continue implementing a comprehensive system of surveillance through expanding the EIP and the FELTP. This network is a phased approach that requires ongoing support for existing country/regional platforms while bringing a high level of focus and attention to develop new sites. An effective network would have a strategic presence across the globe with enhanced information technology and laboratory infrastructure that would allow for the broadest possible detection and response capacities before a significant event occurs. Additional activities include the improvement of early warning systems; researching new viral strains; aiding in collaborations with multinational organizations; and increasing surveillance.

OUTPUT TABLE

OUTPUT TABLE	FY 2004 ACTUAL	FY 2005 APPROPRIATION	FY 2006 ESTIMATE	FY 2006 +/- FY 2005
Global HIV/AIDS				
GAP Countries where CDC will provide technical assistance:				
• HIV counseling and testing	25	25	25	0
• Blood Safety	16	17	17	0
• PMTCT Services	25	25	25	0
• Youth Prevention	19	18	18	0
• Anti-retroviral Treatment	23	24	24	0
• Surveillance	25	25	25	0
• Laboratory Capacity	25	25	25	0
• Monitoring and Evaluation	25	25	25	0
Number of regional offices	4	4	4	0
Number of countries served by regional offices:				
• Number of GAP countries	14	14	14	0
• Number of other countries	27	27	27	0
Global Immunization Activities				
Number of polio vaccine doses purchased for use internationally	500M	500M	500M	0
Number of measles vaccine doses purchased for use internationally	66M	66M	66M	0
Global Disease Detection				
Establish new International Emerging Infections Program network sites	2	2	2	0
Establish new Field Epidemiology and Laboratory Training Programs	1	2	2	0
Other Global Health				

OUTPUT TABLE	FY 2004 ACTUAL	FY 2005 APPROPRIATION	FY 2006 ESTIMATE	FY 2006 +/- FY 2005
Number of countries participating in the Field Epidemiology Training Program	29	32	32	0
Sustainable Management Development Program graduates	235	295	295	0

FUNCTIONAL TABLE

Global Health Budget by Functional Activity (Dollars in Thousands)	FY 2004 Actual	FY 2005 Enacted	FY 2006 Estimate	FY 2006 +/- FY 2005
Global AIDS Program ¹	\$124,882	\$123,821	\$123,883	\$62
Global Immunization Program	\$137,903	\$137,126	\$137,194	\$68
Global Disease Detection	\$11,609	\$21,426	\$33,503	\$12,078
Global Malaria Program	\$9,186	\$9,108	\$9,113	\$5
Other Global Health	\$2,403	\$2,383	\$2,386	\$3
Total -	\$285,983	\$293,863	\$306,079	\$12,216

¹Funding levels for FY 2004 are shown on a comparable basis. A total of \$148.992 million was removed from FY 2004 to reflect the transfer of PMTCT from CDC to the Department of State Office of the Global AIDS Coordinator.

PUBLIC HEALTH RESEARCH

AUTHORIZING LEGISLATION

PHSA §§ 301, 304, 307, 307, 310, 317, 327.

Public Health Research (Dollars in Thousands)	FY 2004 Actual	FY 2005 Enacted	FY 2006 Estimate	FY 2006 +/- FY 2005
BA	\$29,107	\$0	\$0	\$0
PHS Evaluation Transfers	\$0	\$31,000	\$31,000	\$0
Total	\$29,107	\$31,000	\$31,000	\$0
FTE	7	7	7	0

STATEMENT OF THE BUDGET

The FY 2006 budget request of \$31,000,000 for Public Health Research represents level funding with the FY 2005 Enacted level of \$31,000,000.

PROGRAM DESCRIPTION

Public health research is conducted across CDC and works to understand the best methods to assist individuals and communities to establish and maintain healthful lifestyles and environments. The Public Health Research budget activity includes the cross-cutting Health Protection Research Initiative (HPRI). The HPRI was implemented in FY2004 as a multi year program that promotes much needed research in two critical public health areas:

- Promoting health/or preventing disease, injury or disability;
- Protecting people from health threats including infectious, environmental and terrorist threats

The focus in FY 2004 was to support research on developing effective health promotion and prevention programs at the workplace and to support new training efforts and new centers of excellence. In FY 2005, this program addresses the need for a multidisciplinary approach to health marketing, health communication, and innovative statistical methods to estimate the burden of disease. In FY 2006, no new grants will be awarded although the program will fund continuation awards for years two and three of the Health Protection Research Initiative projects.

CDC is committed to funding high-quality public health research that makes the transition from research to practice. All research is proposed by researchers working with communities, health practitioners, and policymakers to address local priority health concerns. All research projects also undergo peer review by expert researchers external to CDC to identify the highest quality proposals.

Funding for Public Health Research for the last five years:

FY	FUNDING*
2001	N/A
2002	N/A
2003	N/A
2004	\$29,107,000
2005	\$31,000,000

*This budget activity has been created as part of CDC's new budget structure; therefore, funding levels are not available for FY 2001 – FY 2003.

PERFORMANCE ANALYSIS

The challenges to public health require a coordinated approach to build capacity throughout the country for practical, applied research by leveraging the scientific capabilities and creativity of experienced investigators by developing a cadre of new public health researchers, and by supporting the collaboration of multidisciplinary scientists.

Current Activities

- In FY 2004, CDC awarded 57 extramural research grants to support research on developing effective health promotion and prevention programs at the workplace and to support new training efforts and new centers of excellence in health economics.
 - In FY 2005 CDC will build on the portfolio of grants to develop health promotion and prevention programs at the workplace, by awarding ten new grants to investigators to support multidisciplinary approaches to urgent public health issues. The topics include: how to best market, communicate, and use the tool of informatics in promoting health/or preventing disease, injury or disability and protect people from health threats including infectious, environmental and terrorist threats. In addition grants may be awarded to support the development and validation of statistical methods to determine the burden of disease on populations. The program will plan and implement an evaluation of investment and outcomes of the HPRI.
 - In FY 2006, CDC will fund continuation awards for years two and three of the HPRI and continue program evaluation efforts.

Significant Accomplishments

- CDC solicits public health research and research training and selects the most highly meritorious applications through peer review. CDC is building a cadre of public health researchers, public health research training programs, and centers of excellence that encourage multidisciplinary approaches. This research will provide much needed evidence to support specific programs, practices and policies that affect health decisions made by the American public and those responsible for health policies and programs.

RATIONALE FOR THE BUDGET

The FY 2006 budget request of \$31,000,000 for Public Health Research represents level funding with the FY 2005 Enacted level of \$31,000,000.

OUTPUT TABLE

OUTPUT TABLE	FY 2004 ACTUAL	FY 2005 APPROPRIATION	FY 2006 ESTIMATE	FY 2006 +/- FY 2005
Public Health Research				
Extramural health promotion research grants:				
New awards	57	10	0	(10)
Continuation awards	N/A	57	67	10

FUNCTIONAL TABLE

Public Health Research Budget by Functional Activity (Dollars in Thousands)	FY 2004 Actual	FY 2005 Enacted	FY 2006 Estimate	FY 2006 +/- FY 2005
Public Health Research	\$14,000	\$31,000	\$31,000	\$0
Extramural Prevention Research	\$15,107	\$0	\$0	\$0
Total -	\$29,107	\$31,000	\$31,000	\$0

PUBLIC HEALTH IMPROVEMENT AND LEADERSHIP

AUTHORIZING LEGISLATION

PHSA §§ 301, 304, 307, 310, 311, 317, 317F, 318, 319, 319A, 319B, 319C, 327, 352, 361, 362, 368, 391, 399F, 1102, 2315, 2341; Federal Technology Transfer Act of 1986, (15 U.S.C. 3710); Bayh-Dole Act of 1980, P.L. 96-517; Clinical Laboratory Improvement Amendments of 1988, §4.

Public Health Improvement and Leadership (Dollars in Thousands)	FY 2004 Actual	FY 2005 Enacted	FY 2006 Estimate	FY 2006 +/- FY 2005
BA	\$215,387	\$266,843	\$206,541	(\$60,302)
PHS Evaluation Transfers	\$17,436	\$0	\$0	\$0
Total	\$232,824	\$266,843	\$206,541	(\$60,302)
FTE	875	846	846	0

STATEMENT OF THE BUDGET

The FY 2006 budget request of \$206,541,000 for Public Health Improvement and Leadership represents a decrease in funding of \$60,302,000 below the FY 2005 Enacted level of \$266,843,000.

PROGRAM DESCRIPTION

The Public Health Improvement and Leadership budget activity supports several cross-cutting areas within CDC whose purposes are to ensure more efficient and effective science and program development. This activity includes the Leadership and Management function, which funds the CDC Office of the Director (OD), coordinating centers, and each constituent center and office. The Public Health Improvement and Leadership budget activity also supports CDC's newly coordinated workforce and career development efforts. Additionally included are the Director's Discretionary Fund, as well as all of CDC's Congressional projects.

LEADERSHIP AND MANAGEMENT

To enhance public health program, science, and practice effectiveness and achieve greater impact on America's health, CDC's funding structure includes the Leadership and Management activity, which supports critical areas such as strategy and innovation, goals management, health disparities, and global health. The Leadership and Management activity also includes operating costs for CDC's OD, CDC's coordinating centers, and the Offices of the Director of the centers at CDC.

CDC OFFICE OF THE DIRECTOR

The CDC OD is comprised of the offices that manage and direct CDC's domestic and international health protection programs. The OD provides leadership, advises on strategy, and develops and evaluates the progress of goals and objectives related to disease prevention and control, including the correlation of these activities to health impact.

CDC is enhancing its efforts to accomplish newly created agency-wide health impact goals by developing and monitoring of agency-wide goals, ensuring that CDC's goals focus on reducing and eliminating health disparities, and by balancing health protection needs, science, and available resources to accomplish CDC's goals. To achieve these goals, CDC's executive leadership is provided with decision-making support through analytical assessments and strategy recommendations for achieving the greatest health impact for the public.

CDC provides leadership, coordination, assessment, and evaluation for minority health initiatives; the OD supports internal and external partnerships; and synthesizes, disseminates, and encourages use of scientific evidence about effective interventions to reduce health disparities. CDC also supports cooperative agreements with academic institutions and national nongovernmental organizations to conduct prevention research, program development, analysis and evaluation to improve the health status of minorities and reduce health disparities. CDC funds key sectors to carry out student and professional research internship and fellowship opportunities that contribute to the improvement of diversity and cultural competency in public health.

CDC has expanded and enhanced its activities related to scientific vision and leadership in science innovation, research, ethics and science administration to ensure stability and commitment to long-term scientific investments as the basis for achieving CDC's two overarching health protection goals. The CDC OD provides coordination for the agency's public health research program, both for intramural and extramural research activities. It upholds scientific ideals, establishes an environment thriving with scientific excellence, innovation and integrity, learning and discovery, and the timely dissemination and translation into practice of scientific information, innovations, and technology with the ultimate goal of improving public health. It facilitates developing strategic and trans-disciplinary approaches for long-term planning and evaluation of CDC's scientific enterprise and ensuring sustainability of CDC's scientific output; establishing and sustaining high-level national and global alliances and synergy; and a coordinated approach to providing scientific foundation for development of public health policies.

CDC's science activities maintain the integrity and productivity of scientists by resolving controversial scientific issues, supporting training and information exchange, and providing direction on matters of scientific integrity. CDC ensures the protection of human subjects in public health research and participates in national and international initiatives in human subject protection. CDC OD also manages CDC's intellectual property (e.g., patents, trademarks, copyrights) and promotes the transfer of new technology from CDC research to the private sector to facilitate and enhance the development of diagnostic products, vaccines, and products to improve occupational safety.

CDC's communications and issues management activities are coordinated and interconnected across the agency through the CDC OD. The OD collaborates with program, policy, and communications professionals to develop multi-faceted strategic responses to issues relevant to the whole agency or enterprise. Working with appropriate coordinating centers, centers, institutes and offices, as well as cross functional teams and workgroups, CDC responds to urgent issues as they emerge and to analyze a range of information to proactively identify and propose responses to issues before they become urgent concerns. These activities ensure that CDC leadership has critical information with which to respond to urgent issues and ensure that enterprise staff and partners are aware of this information and the rationale that supports it.

The OD also incorporates the principal advisor to the CDC Director and manager of daily activities of the OD. These activities ensure that the multi-faceted and cross-cutting issues relating to efficiency and effectiveness of key decisions made by the CDC Director are reviewed and analyzed. The flow of information to the Director and CDC senior staff is also managed, as well as ensuring the CDC director is advised on key programmatic and policy issues. Timely and accurate communication among CDC leadership, coordination and collaboration within the OD and among the CIOs, and liaison activities with HHS and other federal agencies is also coordinated within the OD.

CDC's activities in Washington D.C. allow for a presence to represent CDC leadership and programs to Congress, officials from HHS, and Washington, D.C.-based organizations that are existing or potential partners with CDC. This function provides service and products to these entities so that CDC can achieve its ultimate goal of improving health. In addition, CDC's Washington, D.C. office provides strategic representation for the agency with other federal agencies during management of crises and develops strategic partnerships with other federal agencies to accomplish administration and agency health goals in non-acute but high priority situations. Finally, the office advises agency leaders and scientists about developments in Washington, D.C. that bear on the accomplishment of administration and agency health goals.

Public health practice is a significant area of CDC's activities, ensuring coordination and synergy between scientific and practice activities throughout CDC. The principal means for achieving this level of coordination is to ensure practice-relevant standards, policies and legal tools.

COORDINATING CENTERS, COORDINATING OFFICES, AND CENTER OFFICES OF THE DIRECTOR

CDC's new structure includes several coordinating centers and offices, responsible for the coordination of thematic areas of health promotion and prevention of disease, disability and injury within and across operational centers; identification of areas for collaboration within these thematic areas; reduction of redundancies in business practices in concert with CDC's OD; incorporation of quality science and program to meet the agency's goals; leadership, decision-making, and management of CDC's operational units; and advising the director on scientific, strategic, and programmatic issues. These coordinating centers and offices include: infectious diseases; health promotion; health information and service; environmental health and injury prevention; global health; terrorism; and workforce and career development. The coordinating centers work closely with the center ODs, which are responsible for developing scientific knowledge and quality program development; ensuring scientific credibility and integrity in all areas of expertise needed to address public health; accountability for addressing programmatic key performance indicators; serving as the foundation and core of CDC's science and services; and maintaining expertise needed to address public health emergencies. Funding for these activities and offices is now allocated through the Leadership and Management line to ensure the transparency of programmatic funding by including these costs in a separate line.

PUBLIC HEALTH WORKFORCE DEVELOPMENT

In June 2003, CDC began the Futures Initiative, a strategic transformation process, to meet the public health challenges of the 21st century. As part of this process, CDC announced a newly focused Workforce and Career Development activity to accomplish the following:

- Workforce needs are anticipated and filled through strategic recruitment.
- Skills and competencies of the health workforce are improved and sustained.
- Competent and diverse health and leadership cadres are in place when and where needed.
- Practices of health organizations and systems are improved.
- Workforce development activities are grounded in sound science.
- Best practices, standards, and guidelines are used in workforce and career development efforts sponsored by CDC.

To protect the public’s health across the lifestages and be prepared for outbreaks and public health emergencies, the public health workforce, at all levels and in sufficient numbers, must have the skills and competencies necessary to work effectively in a rapidly changing and complex environment. The amount of knowledge and breadth of skills needed by the public health workforce, whether at CDC or in another setting, is growing and changing more rapidly than ever. To meet these needs, training programs must be transformed into an ongoing process of re-skilling and re-tooling so the workforce can acquire and maintain the competencies needed to perform essential public health services and to satisfy changes in mission, technology, and the content of work.

Toward this end, CDC will make technical assistance available to both internal and external partners on a broad range of training-related issues, including development of training courses and materials, selection of most effective delivery methods, implementation of training-related activities, and evaluation of training efforts. This assistance will be based on the scientific understanding of best practices related to training and further enhanced by CDC’s collective practical experience and expertise in the development and delivery of training. In addition to serving as consultants regarding these general training-related issues, CDC will also convene and work with topic-specific experts if partners request assistance in developing topic-specific training. Finally, CDC, in consultation with the Excellence in Learning Council, will be responsible for developing, revising, administering, and evaluating the policies governing the newly established Individual Learning Accounts at CDC. CDC is committed to providing all employees with flexible learning opportunities that will be accessible through Individual Learning Accounts, at a minimum level of funding per employee per year, beginning in FY 2005.

Funding for Public Health Improvement and Leadership for the last five years:

FY	FUNDING*
2001	N/A
2002	N/A
2003	N/A
2004	\$232,824,000
2005	\$266,843,000

*This budget activity has been created as part of CDC’s new budget structure; therefore, funding levels are not available for FY 2001 – FY 2003.

PERFORMANCE ANALYSIS

PUBLIC HEALTH WORKFORCE – CAPACITY AND COMPETENCY

Current Activities

CDC supports the continued development and administration of 21 state regional and territorial leadership programs. Forty-four states, Puerto Rico and the District of Columbia participate in this effort either sponsoring leadership programs in their states or in collaboration with other states in their immediate geographic region. Approximately 575 health officials are participating in these programs in 2004-2005.

Significant Accomplishments

- CDC, in collaboration with partners, disseminated a competency to curriculum toolkit and competency standards for public health practice, public health law, informatics, bioterrorism, and emergency preparedness and response. These documents address emerging needs and are the basis for national and state workforce development plans.
- CDC published a research agenda for workforce development and examined evidence on linking workforce training/certification and health outcomes.

APPLIED PUBLIC HEALTH TRAINING

CDC continues to provide the U.S. with a trained professional staff able to investigate health problems affecting the nation's population.

Current Activities

- Epidemic Intelligence Service (EIS) officers participate in domestic and international infectious disease investigations ranging from epidemics of meningococcal disease and Ebola hemorrhagic fever to West Nile fever, monkeypox, and Severe Acute Respiratory Syndrome (SARS). As their predecessors eradicated smallpox from the globe, today's officers are working to eliminate poliomyelitis and measles, as well as battling to prevent chronic diseases, violence, and injury. Approximately 70 percent of EIS graduates pursue public health careers.
- The Preventive Medicine Residency combines clinical medical skills with public health practice expertise (e.g., epidemiology, health services management, environmental health). CDC sponsors one of the nation's largest accredited Public Health and General Preventive Medicine Residencies by training 10 residents a year.
- The Public Health Prevention Service Program trains approximately 25 Prevention Specialists annually. This three-year training and service program for master's level public health professionals focuses on public health program management and provides Prevention Specialists with experience in program planning, implementation, and evaluation through specialized hands-on training and mentorship at CDC and state and local health agencies.
- The two-year post-doctoral Prevention Effectiveness Fellowship Program, tailored for economists and health services researchers, trains them to apply the tools of economics and decision analysis to public health policies, programs, and practices; and to systematically assess the costs and benefits of public health programs while emphasizing fiscal accountability and responsible stewardship of public funds.
- The Public Health Informatics Fellowship program trains professionals to translate and apply new and emerging information technologies to support the information needs of public health programs. This two-year fellowship provides a unique training experience that equips professionals with the ability to develop, evaluate, implement, and manage new public health information systems and adapt and support existing systems.

Significant Accomplishments

- As of August 31, 2004, EIS officers have responded to 90 outbreaks in a variety of locations, of which 73 were in the United States and 17 were in other countries. Requests for assistance were primarily for infectious disease problems, but they also addressed environmental health, injuries, maternal and child health, and other problems.
- Prevention Effectiveness Fellows determined the economic burden of dengue in Hawaii, cancer, cardiovascular diseases, obesity and physical inactivity in the U.S., and rubella and congenital rubella syndrome in Mexico and Costa Rica.

NATIONAL LABORATORY TRAINING NETWORK

The National Laboratory Training Network (NLTN) provides cost-effective cutting edge and basic training in the laboratory sciences.

Current Activities

The NLTN provided over 225 courses and trained approximately 20,000 public health and other healthcare workers during FY 2004 in areas such as biological and chemical terrorism preparedness, molecular diagnostics, detection of antimicrobial resistance, and other areas of public health concerns.

Significant Accomplishments

In 2004, the NLTN presented six public health teleconferences for public health laboratory workers nationwide on topics including the Select Agent Rule, Antimicrobial Susceptibility Testing – the Clinical and Laboratory Standards Institute Update and World Health Organization Activities to Strengthen Global Public Health Diagnosis and Biosafety. These courses have been archived for access on the NLTN website.

RATIONALE FOR THE BUDGET

The FY 2006 budget request of \$206,541,000 for Public Health Improvement and Leadership represents a decrease in funding of \$60,302,000 below the FY 2005 Enacted level of \$266,843,000. This includes the restoration of an FY 2005 Labor/HHS/Education reduction of \$148,000.

ONE-TIME PROJECTS

Funding for the Public Health Improvement and Leadership activity includes a decrease reflecting the removal of FY 2005 one-time projects in the amount of \$60,450,000.

OUTPUT TABLE

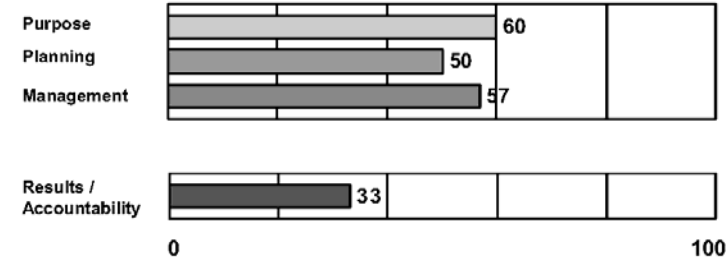
OUTPUT TABLE	FY 2004 ACTUAL	FY 2005 APPROPRIATION	FY 2006 ESTIMATE	FY 2006 +/- FY 2005
Number of new Public Health Informatics Fellows annually	5	5	5	0
Number of Prevention Effectiveness Fellows annually	10	10	10	0
Outside Preventive Medicine Resident assignments sponsored at CDC	2	4	4	0
Number of new Public Health Prevention Service Specialists annually	25	25	25	0
Cumulative national, state and regional leadership development program graduates	725	765	805	40

FUNCTIONAL TABLE

Public Health Improvement and Leadership Budget by Functional Activity (Dollars in Thousands)	FY 2004 Actual	FY 2005 Enacted	FY 2006 Estimate	FY 2006 +/- FY 2005
Congressional Projects	\$41,872	\$60,450	\$0	(\$60,450)
Leadership and Management	\$170,917	\$178,542	\$178,673	\$131
Director's Discretionary Fund	\$0	\$7,931	\$7,936	\$5
Public Health Workforce Development	\$20,035	\$19,920	\$19,932	\$13
Total -	\$232,824	\$266,843	\$206,541	(\$60,302)

Program: CDC: Epidemic Services

Agency: Department of Health and Human Services
Bureau: Centers for Disease Control and Prevention



Key Performance Measures from Latest PART

	Year	Target	Actual
Long-term Measure: Reduced average elapsed time in days from the date of onset of the first case in an outbreak or public health incident to initiation of an investigation or other public health response to an event.	2001		15-23
	2003		13-16

Rating: Results Not Demonstrated

Program Type: Direct Federal

Program Summary:

The Epidemic Services activity at the Centers for Disease Control and Prevention (CDC) was established in 1981 to focus on disease surveillance and epidemic assistance, disease investigation and studies, and laboratory diagnostic references. The majority of Epidemic Services funding has been provided to the Epidemiology Program Office (EPO) at CDC.

The assessment found Epidemic Services at CDC has been managed well overall, but has not documented results on a wide variety of supported activities. The program has had no performance measures on the impact of disease surveillance and training efforts and no evaluations on many activities. Details from the assessment include:

- While individual components have a clear purpose, Epidemic Services overall has lacked a clear and coherent purpose.
- The program is not redundant of efforts outside of CDC, but there are programmatic and administrative redundancies within CDC.
- The program has struggled to place trainees at the State and local level, but it targets resources well overall and there is no evidence that the program subsidizes training and surveillance activities that would have occurred anyway.
- EPO has collaborated well with other parts of CDC, other Federal agencies, and State and international partners to target resources and accomplish its mission.
- EPO has supported numerous evaluations of individual program components that show the surveillance, training and dissemination efforts are largely effective.
- EPO developed a measure on the amount of time between when a disease outbreak or public health incident occurs and when the public health system responds.
- Activities supported by Epidemic Services outside of EPO have not had evaluations and there has been limited information and accountability for these activities.

In response to these factors:

1. CDC reorganized the Epidemic Services activity and EPO by consolidating functions with Health Information and Services activities, Global Health and Public Health Improvement and Leadership at CDC.
2. With the reorganization of EPO, CDC will no longer track EPO's measures, but the organizational units that are now responsible for EPO's functions will adopt these or similar measures in the future.
3. As is shown below, funding is maintained in 2005 and 2006. This funding has been reallocated within CDC as part of the reorganization. Beginning in 2005, Epidemic Services funding will no longer be tracked at the budget activity level.

Program Funding Level (in millions of dollars)

<u>2004 Actual</u>	<u>2005 Estimate</u>	<u>2006 Estimate</u>
92	92	92

PREVENTIVE HEALTH AND HEALTH SERVICES BLOCK GRANT

AUTHORIZING LEGISLATION

Grants: PHSA Title XIX; Prevention Activities: PHSA §§ 214, 301, 304, 306, 307, 308, 310, 311, 317j, 327.

Preventive Health and Health Services Block Grant (Dollars in Thousands)	FY 2004 Actual	FY 2005 Enacted	FY 2006 Estimate	FY 2006 +/- FY 2005
BA	\$131,814	\$130,759	\$0	(\$130,759)
FTE	28	28	0	(28)

STATEMENT OF THE BUDGET

The FY 2006 budget request eliminates the Preventive Health and Health Services Block Grant, resulting in a reduction of \$130,759,000 from the FY 2005 Enacted level.

PROGRAM DESCRIPTION

The Preventive Health and Health Services Block Grant (PHHSBG) has been a tractable source of funding, providing 61 grantees (50 states, the District of Columbia, two American Indian Tribes, and eight U.S. territories) the autonomy and flexibility to tailor prevention and health promotion programs to their particular needs.

A portion of the PHHSBG funding for prevention activities supports public health agencies in six states to improve health information and data systems. In FY 2004, the average award to states was approximately \$2 million.

Funding for Preventive Health & Health Services Block Grant for the last five years:

FY	FUNDING*
2001	\$135,029,000
2002	\$134,958,000
2003	\$134,089,000
2004	\$131,814,000
2005	\$130,759,000

*FY 2004 and FY 2005 funding levels reflect the removal of management and administrative costs under the new budget structure. FY 2001-2003 funding levels are not available in the new structure and include management and administrative costs.

PERFORMANCE ANALYSIS

GOAL: PROVIDE SUPPORT FOR HIGH-PRIORITY STATE AND LOCAL DISEASE PREVENTION AND HEALTH PROMOTION PROGRAMS.

Current Activities

The PHHSBG provides funding support for primary prevention activities and health services that address more than 30 different health problems in local communities. Programs have targeted major issues such as cardiovascular disease, cancer, diabetes, TB, emergency medical services, injury and violence, infectious disease, environmental health, and sex offenses. In addition, the PHHSBG has supported various other activities such as clinical services, preventive screening, laboratory support, outbreak control, training, public education, and program evaluation.

Significant Accomplishments

The following examples represent some of the many programs that have been supported by PHHSBG funds:

- CDC funded a pilot project in Oklahoma for state employees wherein the overall costs for treating cardiovascular disease exceeded \$50.5 million and diabetes costs are \$13.3 million. The project improved health outcomes by reducing the risk of cardiovascular disease by 20% and diabetes by 11%, and reduced

NARRATIVE JUSTIFICATIONS
PREVENTIVE HEALTH AND HEALTH SERVICES BLOCK GRANT

medical costs by 14.3% in the target population. The return on the investment was \$77.40/employee/per year or 21 cents daily.

- CDC carried out activities critical to the diagnosis and treatment of a meningitis outbreak in Mississippi. Over a period of four days, 6,127 doses of vaccine were administered, requiring the efforts of 74 public health nurses, 125 clerical staff, seven physicians and three EIS staff from the CDC. The outbreak was contained and the case fatality rate was 0%.

RATIONALE FOR THE BUDGET REQUEST

The FY 2006 budget request eliminates the Preventive Health and Health Services Block Grant, resulting in a reduction of \$130,759,000 from the FY 2005 Enacted level.

FY 2005 is the final year of funding for the PHHSBG. As the Agency strives to improve efficiency and effectiveness, existing resources will be directed to programs which have traditionally addressed similar public health issues.

OUTPUT TABLE

OUTPUT TABLE	FY 2004 ACTUAL	FY 2005 APPROPRIATION	FY 2006 ESTIMATE	FY 2006 +/- FY 2005
Number of states, territories, American Indian Tribal organizations receiving a Block Grant	61	61	0	(61)

STATE/FORMULA GRANT TABLE

Refer to Exhibit P. for this Table.

BUILDINGS AND FACILITIES

AUTHORIZING LEGISLATION

PHSA § 321(a), Section 319D of the Public Health Improvement Act of 2000.

Buildings and Facilities (Dollars in Thousands)	FY 2004 Actual	FY 2005 Enacted	FY 2006 Estimate	FY 2006 +/- FY 2005
BA	\$260,454	\$269,708	\$30,000	(\$239,708)

STATEMENT OF THE BUDGET

The FY 2006 budget request of \$30,000,000 for Buildings and Facilities represents a decrease of \$239,708,000 below the FY 2005 Enacted level of \$269,708,000.

PROGRAM DESCRIPTION

With the charge of protecting the public health security of the nation, the Centers for Disease Control and Prevention (CDC) is responsible for ensuring adequate facilities and equipment to carry out the agency's mission.

CDC is making dramatic progress to implement its Buildings and Facilities Master Plan so that all facilities, particularly laboratories, are safer for both workers and the community; that the taxpayers' investments in these facilities are protected through effective maintenance and operations; that all CDC facilities are designed and operated responsibly to reduce consumption of resources (energy, water, and capital); and, that strategic planning and asset management processes are identified and implemented to continually align CDC with HHS strategic goals and objectives and the President's Management Agenda. To meet these goals, CDC continuously monitors the adequacy of space assignments and the need for repairs and improvements to our facilities. CDC schedules major and minor renovation, construction, and other facilities projects that it determines to be needed.

CDC is making substantial progress of replacing inadequate and energy inefficient buildings and facilities in Atlanta. In 2005, several new construction projects will become operational on the Roybal and Chamblee Campuses, including the Emerging Infectious Disease and the Environmental Toxicology laboratories. CDC continues to address the remaining inefficient operational environments and other deficiencies in Atlanta and nationwide to ensure that facilities meet modern standards.

There is a growing concern that the next public health emergency could overwhelm current capacities to respond. Both the 1997 Hong Kong Avian virus crisis and the 2001 anthrax attack required displacement of ongoing infectious research programs. Responding to a terrorism event, an environmental disaster, or an unforeseen public health danger such as a global flu pandemic would likely overwhelm CDC's current capacities.

In addition to CDC's government-owned Atlanta campuses, Scientists and Public Health Professionals occupy leased space in 27 different buildings in 5 separate locations costing \$38,000,000 each year. This is a situation that continues to evolve as CDC grows to respond to new public health threats. For reasons of efficiency, physical security, and cost effectiveness, CDC undertook a facility planning effort to assess the work that would be needed to consolidate its Atlanta operations into two secure campuses.

This budget funds annual repairs and improvements to CDC's inventory of nationwide facilities as well as the completion of the Division of Vector-Borne Infectious Diseases Laboratory in Fort Collins, Colorado.

Funding for Buildings and Facilities for the last five years:

FY	FUNDING
2001	\$175,000,000
2002	\$250,000,000
2003	\$266,258,000
2004	\$260,454,000
2005	\$269,708,000

PERFORMANCE ANALYSIS

GOAL: IMPLEMENT SCHEDULED IMPROVEMENTS, CONSTRUCTION, SECURITY, AND MAINTENANCE CONSISTENT WITH AVAILABLE RESOURCES AND PRIORITIES IDENTIFIED IN CDC'S MASTER FACILITIES PLANNING PROCESS.

Current Activities

- CDC is proceeding with five Atlanta Master Plan Projects comprised of 10 buildings, under construction, and infrastructure components. All of these construction activities are anticipated to be complete and in service FY 2005 and FY 2006.
- CDC is in the design phase on two Atlanta Master Plan Projects comprised of three buildings and infrastructure components. It is anticipated that two projects will be completed and in service in FY 2006, and one in FY 2009.
- CDC has begun or completed pre-project planning for three Atlanta Master Plan projects.
- Additionally, CDC has begun pre-project planning for two, non-Atlanta projects.
- Construction on a major laboratory facility in Fort Collins, Colorado, is under way and due to be completed in FY 2006.

Significant Accomplishments

- Efficiency:
 - Construction Manager as Contractor (CMc) - CDC uses a highly competitive process to "pre-qualify" architecture and construction firms to form a pool of resources readily available for use on a task order basis for design and construction. To date, CDC has successfully procured services for six major new construction projects in approximately one-third to one-quarter the time previously needed for traditional procurements.
 - Design/Build (D/B) - In support of the Department of Health and Human Services D/B initiative, CDC is aggressively implementing the use of this process to deliver major new building projects. CDC is in the process of awarding a D/B contract for a 305,000 square foot Research Support Facility, Building 106. Use of this process allows CDC to deliver projects with reduced risk, accelerated delivery and net savings.
- Accelerated Delivery – CDC has determined that projects under CMc and D/B methods reduce delivery time by one-third over other methods.
 - Atlanta Roybal Campus, Building 20: By re-siting the building, CDC is able to accelerate the total project schedule by 19 months. As a result, CDC will be able to invest in additional sustainable design and development features as encouraged by the Federal Facility Council.
 - Atlanta Chamblee Campus, Building 106, Environmental Health Facility: By utilizing the D/B process, CDC is able to accelerate the total project schedule by 12 months. As a result, CDC will be able to invest in additional sustainable design and development features as encouraged by the Federal Facility Council.
- Quality Control – Under both new contracting structures, the architect and builder are brought together from the inception of a project rather than from the completion of a design. This feature ensures a better final product, reduces change orders, and allows better adherence to budget and schedule. These features also provide much greater control of risk for CDC.
- Energy Efficiency – CDC has improved its energy efficiency in Buildings and Facilities by 16% over the baseline year of 1990.

RATIONALE FOR THE BUDGET

The FY 2006 budget request of \$30,000,000 for Buildings and Facilities represents a decrease of \$239,708,000 below the FY 2005 Enacted level of \$269,708,000. CDC plans the following projects at the FY 2006 Request level of \$30,000,000:

CDC requests \$22,500,000 to complete the funding and ensure the continuity of construction of the Division of Vector-Borne Infectious Diseases Laboratory in Fort Collins, Colorado.

CDC also requests \$7,500,000 for nationwide repairs and improvements (R&I).

FORT COLLINS DIVISION OF VECTOR-BORNE INFECTIOUS DISEASES LABORATORY (CONSTRUCTION)

FY 2006 B&F Request/Allocation: (\$22,500,000)

The Fort Collins Division of Vector-Borne Infectious Diseases (DVBID) Laboratory initiative will replace an existing, leased, antiquated, over-crowded Bio-Laboratory and Insectary. The FY 2006 request would fully fund the \$80,000,000 contract award project currently under construction and allow for the project to proceed with an anticipated completion of FY 2006. This initiative will bring the existing vivarium up to AAALAC standards, the insectary up to CDC's Insectaria guidelines, incorporate required physical security requirements, and maintain proximity to the Colorado State University biological and animal laboratory facilities located at the Foothills Research Campus. The project consists of the following components:

- Construction of a new 150,000 Gross Square Foot structure housing approximately 50 scientific and support personnel, BSL-2, 3 and 3+ laboratories, an insectary, a vivarium and Central Utility Plant.
- Provision of limited, CDC dedicated infrastructure connections from the CDC campus to local utilities such as water, gas, sewer, and electric.

REPAIRS AND IMPROVEMENTS (R&I)

FY 2006 B&F Request/Allocation: (\$7,500,000)

CDC will adequately maintain and operate new and existing facilities so that the currently deplorable condition of some facilities does not recur. This nationwide R&I program covers CDC-owned facilities in Metro Atlanta, Cincinnati, Morgantown, Pittsburgh, San Juan, Fort Collins, and Spokane.

FIVE-YEAR PLAN

CDC BUILDINGS AND FACILITIES FIVE YEAR PLAN (DOLLARS IN MILLIONS)						
Facilities Project	Bldg No.	FY 2002 Enacted	FY 2003 Enacted	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Estimate
Roybal Campus:						
Emerging Infectious Disease Lab	18	\$51.6	\$22.2	\$15.0	---	---
Scientific Communications Center	19	\$69.0	\$25.5	---	---	---
East Campus Consol. Lab Project	23/3	---	---	\$123.6	\$71.3	---
Transshipment Center / Campus-wide Utility Infra (includes Labs) / Security	20	\$57.0	\$43.0	\$45.8	---	---
HQ & Emergency Ops Center	21	---	\$89.4	\$19.7	---	---
Epi Office Tower	24	---	---	---	---	---
West Campus Infra/Security	---	---	---	---	---	---
Chamblee Campus:						
Environmental Health Facility	106	---	---	\$12.0	\$101.3	---
Chamblee Campus Entrance and Site Work	---	---	\$6.0	---	\$2.1	---
Research Support Facility	107	---	---	---	---	---
Research Support Facility	108	---	---	---	---	---
Environmental Toxic. Lab	110	\$84.0	\$29.9	---	---	---
Advanced Planning for Atlanta Projects in the 5-year Plan / Master Plan	---	---	---	---	\$0.2	---
Other:						
Ft. Collins, CO	---	\$8.0	\$18.0	\$9.6	\$21.8	\$22.5
Cincinnati (NIOSH)	---	---	---	\$2.4	---	---
Coop Facility Lawrenceville Campus	---	---	\$3.0	---	---	---
IT Security	---	\$6.0	\$6.0	\$6.0	---	---
Other Priorities	---	---	---	---	\$15.0	---
Blast Resistant Glazing	---	---	\$2.5	---	---	---
Emergency Fire and Lifesafety Initiative	---	---	\$2.0	---	---	---
Roybal Campus Main Entrance Security	---	---	---	\$5.7	---	---
Nationwide R&I	---	\$22.2 ¹	\$18.8	\$20.6	\$58.1	\$7.5
TOTAL, CDC B & F Funding		\$297.7²	\$266.3	\$260.5	\$269.7	\$30.0

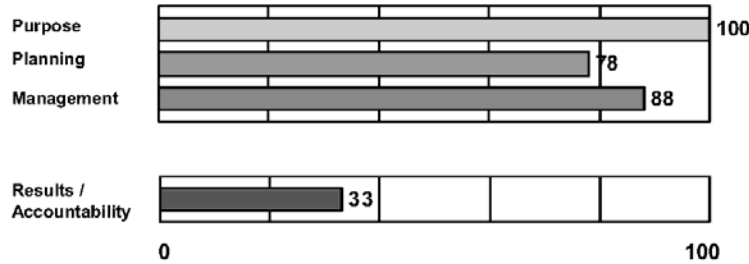
1 Includes R&I projects funded through security.

2 Appropriated funding of \$250 million is different from the amount reported due to inclusion of sources outside of the Buildings and Facilities appropriation, such as Terrorism, Security, and the Director's Discretionary Fund

Program: CDC: Buildings and Facilities

Agency: Department of Health and Human Services

Bureau: Centers for Disease Control and Prevention



Key Performance Measures from Latest PART

	Year	Target	Actual
Long-term Measure: Facility-specific impact on program ability to meet missions for each new construction in output, expansion of research programs and techniques, agency/researcher productivity, reduction in inefficient use of time, other. (Baseline in 2006).			
Annual Measure: Aggregate of scores for capital projects rated on scope, schedule, budget and quality out of 100.	2006	90	
	2007	90	
	2008	90	
Annual Efficiency Measure: Deliver leased space at a percentage below Atlanta's sub-market rate	2003	-10%	-5%
	2004	-10%	
	2006	-10%	

Rating: Adequate

Program Type: Capital Assets and Service Acquisition

Program Summary:

The Buildings and Facilities program at the Centers for Disease Control and Prevention (CDC) works to ensure CDC has safe and efficient facilities and equipment to carry out its mission and that public investments in these facilities are protected through effective maintenance and operations.

The assessment found the CDC Buildings and Facilities activity has a clear purpose and is well managed overall, but has lacked performance measures and a comprehensive evaluation to track its impact on the ability of CDC to more effectively carry out its mission. Details from the assessment include:

- The program uses a master plan of CDC headquarters construction projects to target resources. Senior managers from CDC' centers, institutes and offices helped develop the plan. The program guides repairs and improvements investments using priority rankings and systematic reviews by an internal board.
- As of 2004, 64 percent of projects in the facilities master plan are underway with an investment to date of over \$883 million. The program had not taken steps to measure the impact of these investments on the agency.
- Through the assessment process, the program adopted a new outcome measure that will track changes in areas such as the productivity and expansion of laboratory research and techniques resulting from new facilities. The program will also measure performance on meeting scope, schedule, budget and quality targets.
- The program has met most key milestones, but has exceeded construction costs on individual projects.
- The program is enhancing accountability of individual project managers and the Department of Health and Human Services on the requirements, budget, scope and schedule of projects.
- The program is also beginning to conduct more analyses of trade-offs between costs, schedule and risk for construction projects. The program has supported targeted studies and has used the information to guide program improvements.

In response to these findings:

1. Over the next year, the CDC Buildings and Facilities program will refine the newly adopted long-term measure and develop baselines, ambitious targets and timeframes.
2. The program will explicitly tie budget requests to the accomplishment of annual and long-term goals and will present resource needs more completely and transparently.

Program Funding Level (in millions of dollars)

<u>2004 Actual</u>	<u>2005 Estimate</u>	<u>2006 Estimate</u>
260	270	30

PART RECOMMENDATIONS

Buildings and Facilities was evaluated by PART during the FY 2006 budget cycle. Detailed information is provided below about the status of their PART recommendation.

RECOMMENDATION	COMPLETION DATE	ON TRACK? (Y/N)	
Develop baselines, ambitious targets, and timeframes for the new long-term performance measure.	On-going	Y	
COMMENT ON STATUS			
A Science Program and Facilities working group has been convened to further define the long-term, science output performance measure for Buildings and Facilities. The working group is in the evaluation phase, and has held numerous meetings with CDC's Infectious Diseases Control and Environmental Health programs to discuss project-specific measures, and the feasibility of program-level measures.			
NEXT MILESTONE	NEXT MILESTONE DATE	LEAD ORGANIZATION	LEAD OFFICIAL
Establish targets and baseline data to provide summary indicators for the long-term, science output performance measures (Buildings 18 and 110).	6/30/05	CDC/FMO B&F	Karen Long

BUSINESS SERVICES SUPPORT

AUTHORIZING LEGISLATION

PHSA §§ 301, 304, 307, 310, 3173, 317F1, 319, 327, 361, 362, 368, 399F1; Federal Technology Transfer Act of 1986, (15 U.S.C. 3710); Bayh-Dole Act of 1980, P.L. 96-517

Business Services Support (Dollars in Thousands)	FY 2004 Actual	FY 2005 Enacted	FY 2006 Estimate	FY 2006 +/- FY 2005
BA	\$251,273	\$278,840	\$263,715	(\$15,126)
PHS Evaluation Transfers	\$30,953	\$0	\$0	\$0
Total	\$282,226	\$278,840	\$263,715	(\$15,126)
FTE	1,180	1,142	1,143	1

STATEMENT OF THE BUDGET

The FY 2006 budget request of \$263,715,000 for Business Services Support represents a decrease of \$15,125,000 below the FY 2005 Enacted level of \$278,840,000.

PROGRAM DESCRIPTION

Over the past two years, CDC's business support structures and systems have been significantly revamped to achieve greater effectiveness and efficiencies. CDC has revised its budget structure to ensure greater transparency and accountability for programmatic dollars by identifying and separating costs related to business operations and processes into the Business Services Support budget activity. The work conducted within this activity supports the top-notch public health programs and science that make CDC America's lead public health agency and a respected resource for improving public health worldwide.

Guided by the Futures Initiative and the President's Management Agenda (PMA), CDC has combined best practices of the business community with those of the public sector to become a more efficient, effective, and accountable steward of taxpayer dollars. To meet the goal of providing cutting-edge business services, CDC has engaged in numerous business process improvements and continues to adapt to realize additional benefits from advancements in this area.

OFFICE OF THE CHIEF OPERATING OFFICER (OCOO)

Current Activities

The OCOO oversees business services support for CDC and ensures that CDC's business practices are efficient by applying proven public- and private-sector systems and practices. This office also oversees and carries out PMA functions. Please refer to the PMA section of this document for more information about CDC's accomplishments and activities related to PMA. OCOO assures that funds are appropriately allocated throughout the agency and that CDC's programs have the tools and facilities needed to ensure top-quality science and programs. It is responsible for protecting CDC employees' health and safety.

The OCOO uses Key Performance Indicators (KPIs) to evaluate the performance and effectiveness of business performance. The KPIs provide management with a snapshot of critical information about the most important aspects of business operations. Business-related KPIs measured at CDC include hiring, personnel, workforce development, grants and contracts, financial management, information technology, travel, diversity, and facilities. KPIs are an essential performance management tool, through

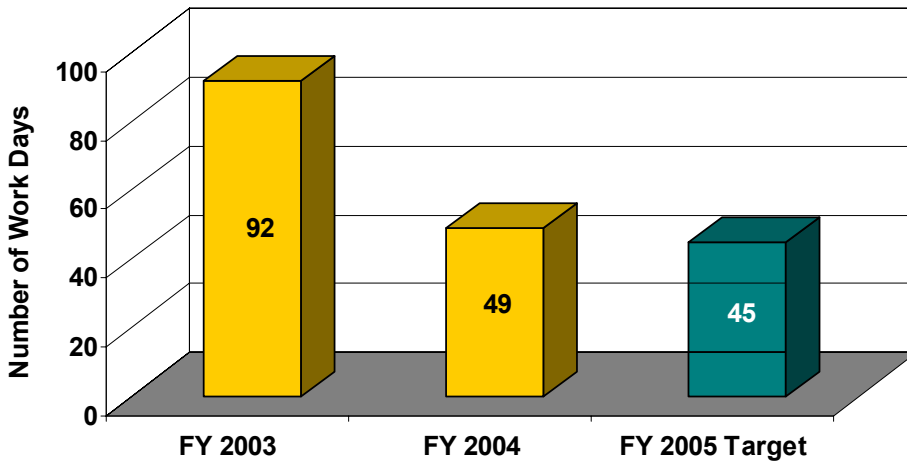
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|---|
| <p>The offices within the OCOO include the following:</p> <ul style="list-style-type: none"> ▪ Administrative Services and Program ▪ Alternative Dispute Resolution ▪ Atlanta Human Resources Center ▪ Capital Planning and Investment Control ▪ Ethics ▪ Financial Management ▪ Facilities Planning and Management ▪ Security and Emergency Preparedness ▪ Information Technology Services ▪ Management Analysis and Services ▪ Chief Information Security Officer ▪ Procurement and Grants |
|---|

which CDC proactively manages administrative performance, ensuring efficient use of appropriated funding.

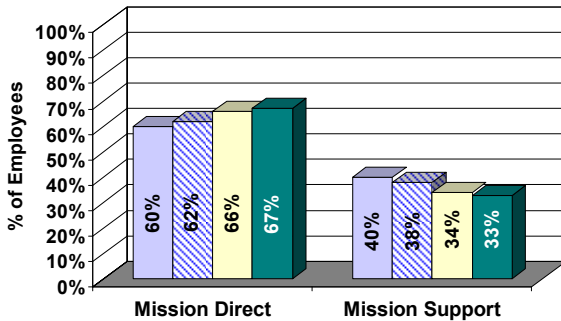
Significant Accomplishments

CDC, with HHS' guidance, completed the restructuring of its human resources office to the HHS Atlanta Human Resources Center (AHRC). This human resources office restructuring eliminated 76 full-time equivalents, reflecting a 30 percent staff reduction. Concurrent operation efficiencies nearly halved hiring time. The time from AHRC's receipt of a hiring request to the day the job offer is made was reduced by 47 percent between 2003 and 2004. Additionally, this office led the effort to shift more human capital to frontline public health, increasing CDC's positive impact on America's health and wellbeing.

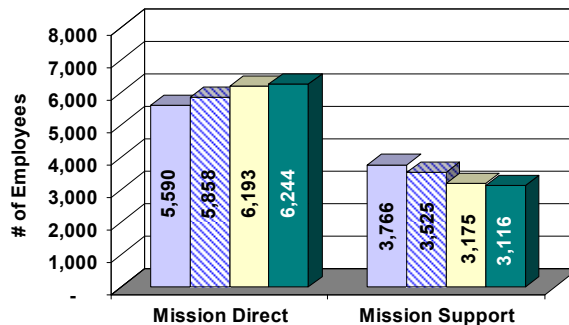
Days to Hire



Mission Direct vs. Mission Support
(% of Employees)



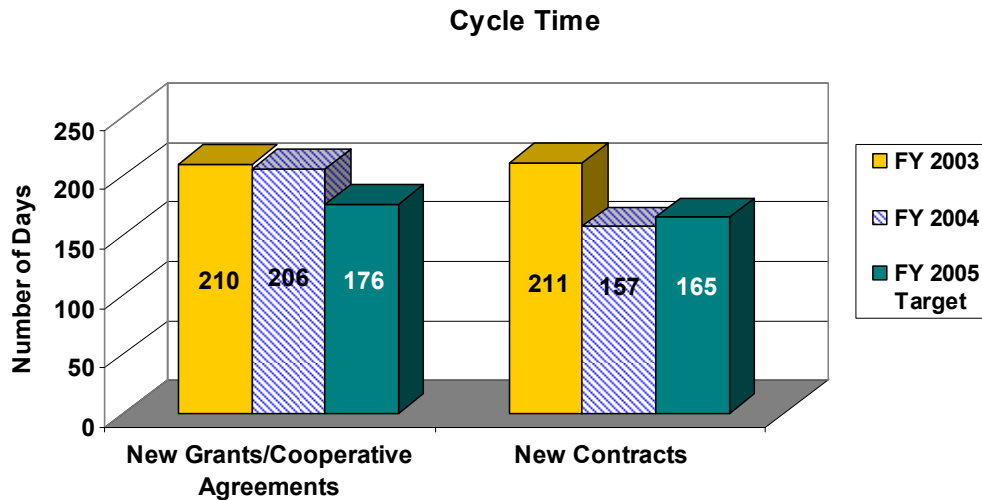
Mission Direct vs. Mission Support
(# of Employees)



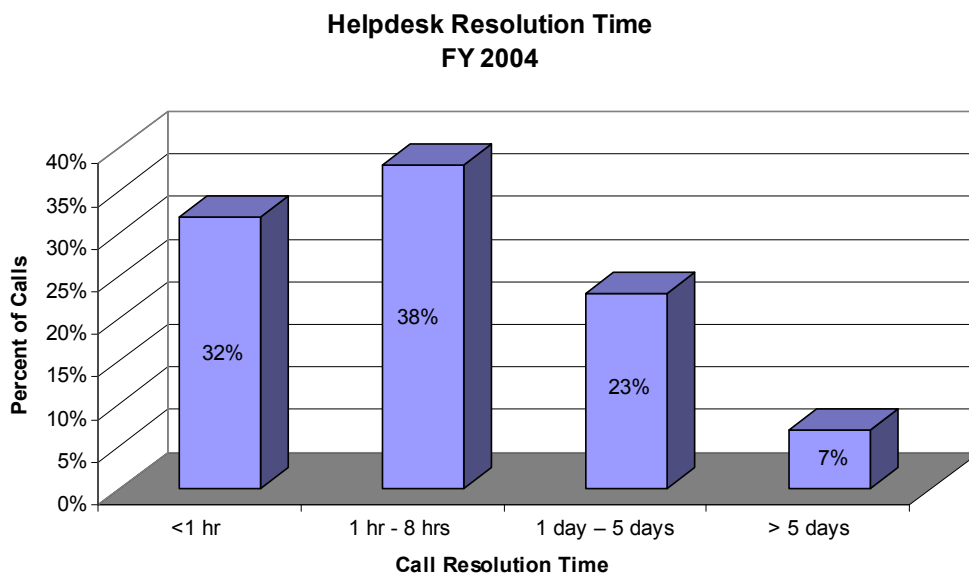
Legend: FY 2002 (light blue), FY 2003 (hatched), FY 2004 (yellow), FY 2005 Target (teal)

CDC's Procurement and Grants Office (PGO) is responsible for acquisition and assistance activities to enable CDC's centers, institute, and offices to implement health-related programs and initiatives. PGO also protects the public trust by ensuring the integrity, efficiency and effectiveness of the financial assistance and acquisition processes. PGO provides procurement management of all CDC acquisition and assistance awards. PGO is also implementing process improvement measures and KPIs to decrease the amount of time taken to award contracts and grants, thereby increasing the speed with which public health interventions can be put into place. In just a year, the cycle time for grants and contracts has been reduced by 24 percent.

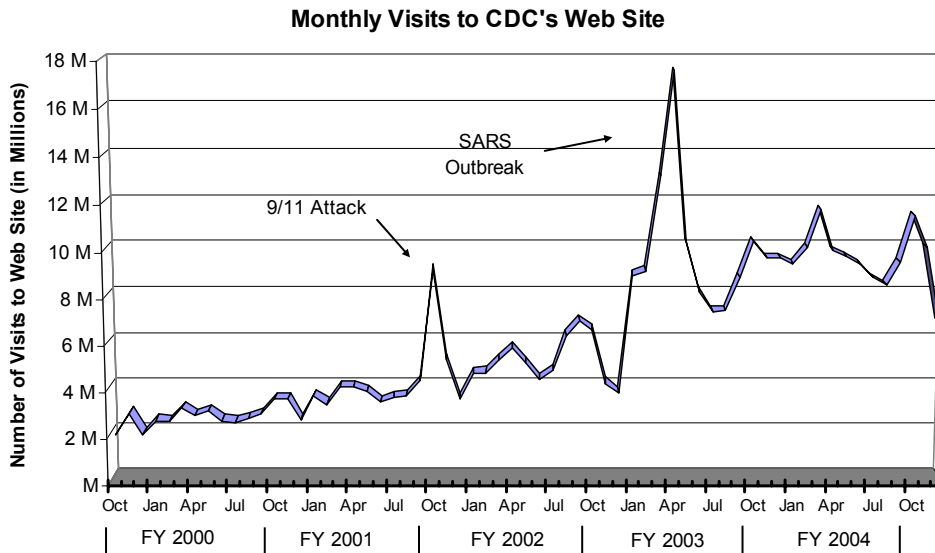
The FY 2005 target of 165 days is an aggressive target that is significantly lower than the FY 2003 baseline. Although it is slightly greater than FY 2004 actual performance, CDC seeks to ensure that process improvements established in FY 2004 are sustainable before adjusting the target. Also, new procedures are being developed in FY 2005 to improve efficiency, which may slightly increase cycle time over FY 2004 levels due to the initial implementation complexities.



CDC's Information Technology Services Office (ITSO) has been created to consolidate all common CDC IT infrastructure services to achieve higher performance at lower cost. During its first year, ITSO reduced costs over 20 percent while increasing service offerings, expanding service hours and locations, improving service levels, and reaching a "best-in-class" customer satisfaction result.



Visits to the CDC website reflect the quality, timeliness, trust, and value of CDC's information to the public. During public health emergencies, visits to the site spike dramatically as the public seeks emergency related information. Overall, CDC's website has seen steady year over year growth in visitors.



In addition to the KPIs included in this document, OCOO is responsible for tracking and reporting many business services functions. The Business Services Support line is an extension of this system of accountability for business. By separating these costs, we assure greater transparency and accountability, ensuring funds are used for their intended purpose and by providing CDC with one funding stream through which its major business processes are managed. These include the OCOO as well as resources for areas such as rent, utilities, telecommunications, and security for CDC employees.

FY	FUNDING*
2001	N/A
2002	N/A
2003	N/A
2004	\$282,226,000
2005	\$278,840,000

*This budget activity has been created as part of CDC's new budget structure; therefore, funding levels are not available for FY 2001 – FY 2003.

RATIONALE FOR BUDGET

The FY 2006 budget request of \$263,715,000 for Business Services Support represents a decrease of \$15,125,000 below the FY 2005 Enacted level of \$278,840,000. This decrease reflects various administrative savings that CDC anticipates realizing as a result of various consolidations and the new CDC budget and organizational structure. The amounts requested in this budget line will be combined with overhead assessments on Occupational Safety and Health, as well as overhead assessments on funding appropriated in other accounts.

TERRORISM

AUTHORIZING LEGISLATION

PHSA §§ 301, 307, 311, 317, 319,319A, 319D, 319F, 319G and 361-368, (42 U.S.C, 262 note), 2801-2811.

Terrorism (Dollars in Thousands)	FY 2004 Actual	FY 2005 Enacted	FY 2006 Estimate	FY 2006 +/- FY 2005
Total	\$1,507,211	\$1,560,445	\$1,616,723	\$56,278
FTE	538	582	582	0

STATEMENT OF THE BUDGET

The FY 2006 budget request of \$1,616,723,000 for Terrorism represents an increase of \$56,278,000 over the FY 2005 Enacted level of \$1,560,445.

PROGRAM DESCRIPTION

CDC is in the process of strengthening its preparedness framework to encompass the agency's overarching preparedness goals. FY 2004 program activities are reported on below, and these retain the format and process in place to date. As CDC moves forward with its process of aligning projects to the new agency preparedness goals, the format for the budget and performance integration will be revised.

Over the past five years, the Department of Health and Human Services (DHHS) has invested in the planning and development of the foundation for the nationwide public health terrorism preparedness and response readiness program. As part of the Department of Health and Human Services, CDC has become an integral part of the program. CDC's mission in this area is to prevent death, disability, disease and injury associated with urgent health threats by improving preparedness of the public health system and the public through excellence in science and services. CDC is attempting to achieve this mission through a variety of efforts.

CDC's first such endeavor is through investing in preparedness and response efforts; challenging but achievable standards for public health readiness are being developed and will be applied nationally. CDC also engages in partnerships with organizations that are traditionally outside the public health community (hospitals, community agencies, medical care delivery service providers, EMS, fire and police). These tie personal and community health together for greater opportunities for early intervention. Additional efforts have also been taken to expand technology and knowledge. By using modern tools to enhance surveillance, epidemiology and laboratory capacity, CDC can respond effectively to routine emergency public health events.

CDC has created a preparedness framework comprised of three key components designed to provide a structure for the agency's strategic goals and comprehensive terrorism preparedness and emergency response program. First and foremost is detection. CDC believes all possible measures should be taken to detect an event so intervention can begin as early as possible to minimize mass trauma. Following this is CDC's commitment to thorough investigation and rapid response. CDC and its public health partners are putting into place plans and systems designed to respond to and contain a catastrophic event. The final component is control, containment and recovery. The emphasis here is on assuring state and local ability to quickly receive and distribute the Strategic National Stockpile, a national repository of life saving pharmaceuticals, medical materiel, and equipment.

CDC's goal is to provide around the clock support to state and local officials, to ensure they have the disaster preparedness resources they need. The first step in achieving that goal is assuring the ability to detect an event has taken place so intervention can begin as early as possible to minimize mass trauma, so plans and systems are in place to respond to and contain a catastrophic event.

As part of the system to quickly recognize and react to disease outbreaks, CDC has begun investments in strengthening early detection and containment of biological public health threats in the Biosurveillance initiative, which began in FY 2004 and will be more fully implemented by the end of FY 2005. The goal is to have supplies of needed vaccines and antibiotics purchased and stored under the protection of the Strategic National Stockpile, more quarantine stations operational at airports and places of entry, and increase the ability to receive and process information in real-time from laboratories monitoring public health. While initial investments occurred in FY 2004, FY 2005 funding levels will allow for the projects to properly expand capacity. Through BioSense, CDC is assuring that the tools of an epidemiologist will be brought into the 21st century by connecting multiple disparate data sources into

a fully functioning, real-time surveillance system. Federal, state and local health officials will have access to real-time data that could potentially be the first sign of a public health emergency, or even a bioterrorist attack. This exciting new tool will give public health practitioners a weapon to better protect the security of the homeland.

The FY 2006 budget for terrorism will strengthen CDC's ability by continuing to invest in preparedness and response efforts, expanding terrorism preparedness for chemical, biological, radiological and mass trauma events, and assessing the effects of these investments on public health preparedness capacities.

Funding for Terrorism for the last five years:

FY	FUNDING
2001	\$180,919,000
2002	\$2,251,523,000
2003	\$1,235,424,000
2004	\$1,507,211,000
2005	\$1,560,445,000

PERFORMANCE ANALYSIS

DETECTION

Detection activities center on the public health system's capacity to rule out the presence of hazardous agents, specifically chemical, biological, radiological, or nuclear agents (CBRN). To perform the tasks effectively, federal and state laboratories require sufficiently trained staff with the requisite scientific knowledge. In addition to basic competency training, these staffs require ongoing training, education and development to maintain proficiency and embrace new and improved technology. Further, state laboratories must have established communication systems to support timely transfer of samples and routine reporting.

GOAL: THE RAPID DETECTION OF PUBLIC HEALTH EMERGENCIES INVOLVING CBRN AGENTS.

Current Activities

CDC is currently engaged in numerous activities designed to enhance its ability to detect a potential emergency. One of the oldest and most respected efforts is the Epidemic Intelligence Service (EIS). These "disease detectives" provide expert assistance in the event of an emergency. CDC is also collaborating with the National Association of County and City Health Officials (NACCHO) and the Council of State and Territorial Epidemiologists (CSTE) to define current epidemiology capacity and identify challenges in building capacity. Additionally, CDC has developed, and is using, *Rapid Toxic Screen*, which is a series of analyses that can rapidly screen human blood and urine samples for 150 chemical agents. CDC is also dedicating significant support to BioSense, as a part of Public Health Information Network (PHIN) preparedness and the national Biosurveillance initiative, it has been developed to support early event detection and represents a new approach to public health surveillance based on the secondary use of health care and health related data.

Significant Accomplishments

- In an effort to maximize and make the most efficient use of funding possible, CDC has endeavored to engage in projects that show tangible results. To that end, significant strides have been made. Now 100 percent of state, territorial and city awardees have developed public health emergency preparedness and response plans, 95 percent have systems being developed to receive and evaluate urgent disease reports on a 24/7 basis these systems are working on becoming PHIN compatible and able to receive health alerts from the Health Alert Network (HAN), and 56 percent of CDC's awardees have established systems for ongoing training in disease detection and epidemiology. CDC has also dispersed forty-eight of the 167 current EIS Officers to state or local health departments, reaching the targeted level. All EIS Officers now receive training in terrorism preparedness and emergency response.
- CDC has increased the number of Laboratory Response Network (LRN) labs to 139, up from 91 in 2001. These labs are now located in all 50 states and the LRN even boasts several installations abroad. Ninety-six percent of these labs can confirm the presence of anthrax, 94 percent can confirm tularemia, and 63 percent can perform presumptive screening for smallpox. CDC has trained more than 8,800 clinical laboratorians to play a role in the detection, diagnostics, and reporting of public health emergencies. Since its inception in 1999, there has been dedicated funding for the acquisition of LRN reagents. Maintaining and strengthening

LRN capacity depends on CDC's ability to ensure the production, validation, and distribution of the LRN's proprietary reagents. Following the administration's philosophy of tight financial management and result oriented projects has enabled the LRN project to enjoy its current state of readiness and capacity.

- Through its Laboratory Integration Program, CDC has established Laboratory Program Advisors in each state to address preparedness and emergency response. In addition, more than 4,400 BT-capable laboratories have been identified and a list has been made available to CDC and state and local public health partners. Further, a secure web-accessible database has been expanded to reach 180,000 clinical and public health laboratories.
- The Missouri Department of Health and Senior Services initiated a powerful DNA fingerprinting system that provides rapid identification of a wide variety of infectious diseases including critical BT agents. That and amplification methodology, significantly reduces the time it takes to identify critical agents from three days to 2-4 hours.
- Immediately following the anthrax incidents, South Dakota began the design and construction of the first mobile laboratory in the U.S. It will be used to provide surge capacity during an event at either the state laboratory or on the scene, provide training in rural locations, and serve as the main public health laboratory if the current facility were incapacitated and as a screening area for highly suspect specimens or packages.
- The initial implementation of BioSense has concentrated on health care and health related data such as diagnosis, procedures, and laboratory test orders and data from other federal agencies such as Department of Defense (DoD) and Department of Veterans Affairs (VA) who have partnered to help support this effort. Since the program's beginning, it has begun receiving daily data feeds from an initial set of data providers, and to date has received and processed over 416 million records from DoD and VA; data is analyzed using state-of-the-art detection algorithms to identify health events in major metropolitan areas nationally and to help rule out false alarms from environmental signals; the BioSense application has been made available to 34 city jurisdictions and all 50 states through the enrollment of BioSense administrators and standard users and currently supports over 330 users in all states and major metropolitan areas. CDC established the BioIntelligence Center to monitor incoming data from data providers; contracts were developed to support the provisioning of data from regional and local data sources and for implementing analytical algorithm evaluation and development; a national working group was formed to refine and integrate laboratory test data into the BioSense interface; laboratory test orders and results from a national clinical laboratory performing over 300,000 tests daily were incorporated into the analytical output of the BioSense application for evaluation (to date, more than 300 million clinical lab records have been received and processed); and specific monitoring capabilities for nationally significant events such as the G-8 Summit and the Democratic and Republican National Conventions were developed and implemented.

INVESTIGATION AND RESPONSE

Investigation and response activities are imperative for early detection of a potential terrorist agent. Early detection requires additional competencies, and integrated communication/information technology systems. This massive effort requires coordination and communication between federal agencies (e.g., DHS, DHHS, DOJ, DOD, USDA, VA, etc.), state and local agencies, and private/non-profit organizations and associations. Currently, CDC relies heavily on the Director's Emergency Operations Center (DEOC) to coordinate and disseminate critical information to first responders and organize and monitor the deployment of CDC field responders. The DEOC allows information to be readily available and up to date to those involved in the initial stages of an event. CDC is currently investing in several activities that will allow the public health community to detect events of public health importance much more quickly including the BioSense program, which has the potential to decrease morbidity and mortality after a biological threat has been identified.

CDC is also utilizing the Centers for Public Health Preparedness (CPHP) to assist in efforts to accurately investigate and respond to public health emergencies involving CBRN agents. This partnership, linking academic expertise state and local health departments, allows for frontline participants to access the knowledge and experience present in the Centers. CPHPs will be developing standards for preparedness education requirements for specific health disciplines to ensure education consistency across the national network. Currently CDC requires CPHP preparedness education activities to be based on a defined community need, and proposed in collaboration with state/local/tribal/federal health partners. By September 2005, CPHP will be publishing a compendium of evaluation models used for measuring effective preparedness education that were developed and used by CPHPs over the past four years.

HAN is the alerting component of CDC's PHIN, and one of the critical pieces of CDC's investigation and response efforts. HAN will provide communities across the U.S. the capability to utilize standards-based, interoperable technologies that will allow for public health stakeholders at all levels of government to communicate with critical

community partners, including acute care hospitals, law enforcement, first responders, pharmacies, and many other professionals critical to community protection. In addition, CDC will be using the HAN infrastructure to deploy critical information for public health practice.

The creation of the Strategic National Stockpile (SNS) has allowed CDC to prepare for mass casualty events and respond by delivering pharmaceuticals and selected other medical supplies to any point in the U.S. within 12 hours. To ensure adequate supplies of materiel, the FY 2006 budget request includes increased funding to purchase additional countermeasures. Funding is also included in the FY 2006 budget request to support deployable federal mass care facilities for the HHS Federal Medical Contingency Stations program, a federal-level contingency care program to be utilized in the event of a mass-casualty incident. The SNS also will continue to provide support to the Cities Readiness Initiative (CRI), a collaborative effort with the United States Postal Service and urban areas considered to be at the highest risk of and vulnerable to bioterrorist attacks. A major goal of the CRI is to prepare cities to distribute antibiotics to their residents within 48 hours in the event of a wide-area outdoor release of the anthrax organism.

GOAL: TO PROVIDE RAPID INVESTIGATION AND RESPONSE TO PUBLIC HEALTH EMERGENCIES INVOLVING CBRN AGENTS.

Current Activities

- CDC has made great strides in enhancing efforts to properly investigate and respond to potential terrorist attacks. CDC has a cadre of multidisciplinary subject matter experts ready to deploy 24/7 in response to an emergency depending on mission requirements and needed skill sets. CDC is also maintaining close contact with state and local public health departments by the assignment of Career Epidemiology Field Officers (CEFOs) to their departments. These individuals also provide critical epidemiological expertise.
- The creation of Epi-X, The Epidemic Information Exchange, enables CDC to provide secure, moderated communications and notification services. By the end of FY 2004, Epi-X had enrolled 2,100 key public health officials nationwide, compared with 200 enrollees in 2001.
- CDC is also proud of the work being done by PHIN. Its efforts are focusing on integrating several systems into a unifying framework to better monitor applicable data streams for early detection. PHIN will enable consistent, secure exchange of response, health, and disease tracking data between public health partners. PHIN is composed of five key components: detection and monitoring, data analysis, knowledge management, alerting, and response.
- Currently, 41 CPHPs are established in universities within schools and colleges of public health (majority), medicine, nursing, veterinary medicine, pharmacy, biological sciences, in a community college, and in several university-based medical and health science centers.
- All fifty states, five territories, three freely associated States of the Pacific, the District of Columbia, and three major U.S. cities participate in HAN. HAN is building capacities in these jurisdictions including: modern interoperable PHIN standards-based information and communication systems; high-speed communications, including early-warning broadcast alerts, among CDC and state and local health departments; the identification and connection of key public health stakeholders (law enforcement, fire departments, hospitals, 911 centers), allowing for the high-speed exchange of critical public health information to improve the practice of public health; and linkages between all local public health jurisdictions via continuous, high speed, secure connections.

Significant Accomplishments

- CDC's drive towards more effective government can be seen through partner and agency production of measurable results. To this end, 100 percent of awardees have developed or are in the process of developing a statewide communication system capable of sending and receiving critical health information, 24/7. Additionally, PHIN can quickly reach one million recipients with health alert and advisory messages, including 90 percent of all county public health agencies, up from 68 percent in 2001. CDC has established, prepared and trained employees with CBRN and explosive subject matter expertise ready on a 24/7 basis to be deployed in the field during an outbreak or incident.
- In New York State, the Hospital Emergency Response Data System (HERDS) was developed, in conjunction with Greater New York Hospital Association. HERDS allows real time tracking and reporting of vital resources available at hospitals during an emergency so that resources can be transferred/shared where critically needed.

- The use of terrorism funding in Maine strengthened the public health infrastructure, allowing the local health officials to better respond to an arsenic poisoning incident. The expertise of a regional nurse epidemiologist, a medical toxicologist, and Maine's HAN were all available, allowing better treatment and dissemination of information because of terrorism funding. Treatment and examination was accomplished in a day, while two years ago, it would have taken a day to get someone on site and another day to analyze the data. Terrorism funds provided a stockpile of the arsenic antidote, a chelation agent, along with other chemical antidotes, and it was being readied for distribution to every hospital in the state.
- The CPHP Network is providing preparedness education and other requested services to health agencies in 46 states. These centers have developed over 300 courses and are featured in a resource center developed by the Association of Schools of Public Health (ASPH). Additionally, the University of California at Los Angeles Center for Public Health and Disasters trained over 300 workers in seven county health agencies. Ninety-four percent of participants rated training as extremely effective.

CONTROL, CONTAINMENT AND RECOVERY

Every effort needs to be made to mitigate the impact of outbreaks of infectious disease, mass trauma events, and other public health threats and emergencies. The most effective means of accomplishing this is to have in place specific control, containment and recovery measures. The CDC response to SARS and the anthrax attacks are excellent examples of these efforts. In order to prevent injury, disability, or death; it is important to rapidly identify and respond to infectious disease outbreaks, mass trauma events, and other public health threats and emergencies. However, once identified, it is important to contain the event to prevent its spread. If initial attempts at containment fail, it is important to quickly recover from the effects of the event. It is important to remember that control, containment and recovery are only possible if the safety of emergency responders can be assured. Proper personal protective equipment requires research, identification, and availability to emergency responders.

GOAL: TO QUICKLY CONTROL, CONTAIN, AND RECOVER FROM PUBLIC HEALTH EMERGENCIES INVOLVING CHEMICAL, BIOLOGICAL, RADIOLOGICAL, OR NUCLEAR (CBRN) AGENTS.

Current Activities

- CDC is working on many different fronts to ensure the best possible control, containment and recovery during a CBRN event. By examining the link between physical and mental illness, trauma and violence, and preparedness, a better understanding of the psychological and behavioral responses to terrorism can be gained, thereby enabling CDC to build resiliency in the nation's communities. Collaboration with SAMHSA, HRSA, and NIMH is ongoing to enhance exposure and mass casualty management strategies from a psychosocial standpoint, and CDC is also working closely with external partners (e.g. the VA, DOD, American Psychiatric Association; American Psychological Association, and the American Red Cross Headquarters for Disaster Mental Health Response) to develop a behavioral health research and preparedness agenda as part of a ten year plan.
- In an effort to build on existing knowledge, CDC and the U.S. Department of Agriculture have implemented the Select Agent Program. This is designed to help further the nation's capacity to monitor and regulate entities that possess, use, and transfer select agents and toxins to ensure their safety and security.
- The Strategic National Stockpile (SNS) has also continued in its efforts to ensure the safety of the nation. The SNS manages 50-ton, 12-hour, push packages that contain supplemental medicine and medical supplies designed to be used in the event of mass casualty incidents. These packages can be delivered to any point in the country within 12 hours. Additionally, to assist states with the receipt, staging, storage, and distribution of the materials, there are two training and education packages.
- With expansion of the SNS, the next logical step is to assist states and cities further to plan for receipt, warehousing, and dispensing of medicines and medical supplies. To target funding and enhance preparation for major public health emergencies, the Cities Readiness Initiative (CRI) has been created. CRI includes a partnership with the United States Postal Service (USPS) to deliver antibiotics within 48 hours to their residents. Twenty-one pilot cities have been selected and are receiving preparedness training for mass prophylaxis distribution. The next group of CRI cities is currently under consideration. With resources geographically dispersed at the local level, the initial 21 cities will exercise and train and provide government recommendations resulting in lessons learned and best practices. This knowledge will be incorporated into the expansion of follow-on CRI cities.

Significant Accomplishments

- CDC's quick and decisive action allows numerous successes in the effort to control, contain, and recover from outbreaks of infectious diseases. One of the best examples is the rapid reaction that accompanied the SARS outbreak. CDC coordinated state and local epidemiological and laboratory response efforts to help detect, control and respond to areas with potential SARS cases.
- Working with experts, CDC issued a performance standard for self-contained breathing apparatus (SCBA) respirators and a performance standard for full-face piece air-purifying (FFAP) respirators for occupational use by emergency responders involving CBRN agents.
- CDC's Select Agent Program has also inspected 338 entities since the new regulations became effective.

RATIONALE FOR THE BUDGET

The FY 2006 budget request of \$1,616,723,000 for Terrorism represents an increase of \$56,278,000 over the FY 2005 Enacted level of \$1,560,445,000. This includes the restoration of an FY 2005 Labor/HHS/Education reduction of \$269,000.

The FY 2006 budget request reflects CDC's commitment to building preparedness and response capabilities across the nation while ensuring funding is directed to those activities that can most effectively and efficiently achieve those goals. Therefore, while recognizing the competing priorities, CDC proposes an increase in the amount of \$203,200,000 for strengthening the SNS.

STRATEGIC NATIONAL STOCKPILE: (+\$203,200,000)

As new threats emerge, and replacement medical countermeasures are developed, additional supplies of pharmaceuticals and medical materials will be acquired for the SNS. While this greatly improves capacity and national readiness levels, it also increases the financial and physical demands on the SNS. Therefore, in order to ensure that the SNS continues to expand and maintain necessary readiness levels, increased funds are required.

These funds will allow the SNS to expand its capabilities by obtaining additional countermeasures, e.g. anthrax antibiotics; to achieve and maintain readiness for a quick and effective response to national, state and local governments in the event of terrorist or mass trauma event. For example, an extra ten million treatments of anthrax antibiotics will be purchased, extending treatments to 60 million people. Additionally, the augmentation of project BioShield will bring additional products under the management of the SNS. These newly acquired vaccines and antibiotics will be stored in the SNS warehouses and a portion of the increase will ensure enough secure space is available for these new BioShield products. The readiness capability furnished by the SNS provides the nation with an essential component of a response to a terrorist or mass trauma event.

To address the nation's shortfall in providing an all-hazard mass casualty care event, a federal-level contingency care program is under development pursuant to HSPD-10, the Presidential directive setting policy for protection against a bioterrorism attack. HHS's Federal Medical Contingency Station (FMCS) is co-managed by the Office of Public Health and Emergency Preparedness and SNS and has designated \$50 million from the FY2006 budget for the procurement of additional units, management, shelter warehousing, supplies and training. This program compliments the Cities Readiness Initiative by targeting resources in response to mass casualty events.

PROGRAM REDUCTIONS: (-\$147,191,000)

State and Local Cooperative Agreement (-\$129,534,000): CDC's funding to state and local health departments through its Cooperative Agreement on Public Health Preparedness and Emergency Response has contributed significantly to upgrading those state and local public health jurisdictions' preparedness for a response to bioterrorism, outbreaks of infectious disease, and other public health threats and emergencies. While recognizing competing priorities and some state and local level constraints to effectively utilize grant funds, CDC proposes reducing \$129,534,000 million from the state cooperative agreement so that additional funds can be allocated to the SNS in order to make the most effective use of the funding available, while maintaining support of and strengthening state preparedness through an expanded and improved SNS program.

Anthrax Research Program (-\$16,666,000): In addition, CDC proposes a reduction in the amount of \$16,666,000 from its anthrax research study. The long running anthrax study will be nearing its conclusion. The information gleaned over the course of this study will not be compromised due to its cessation, and the expected benefits will have been gained by the time of the project's completion.

IT Reduction and Administrative Savings (-\$991,000): CDC recommends a reduction of \$991,000 due to a combination of administrative savings expected from various consolidations and the new CDC budget and organizational structure, as well as a reduction in the cost of IT expenditures due to increased interconnectivity and advancement of IT systems.

OUTPUT TABLE

OUTPUT TABLE	FY 2004 ACTUAL	FY 2005 APPROPRIATION	FY 2006 ESTIMATE	FY 2006 +/- FY 2005
Percent of states and major city project areas with enhanced laboratory capacity for rapid testing of potential terrorism agents	100	N/A	N/A	N/A
No. of federal, state and major city/county laboratories participating in a national state-based laboratory network to provide rapid and accurate diagnostic and/or reference support (LRN)	134	160	N/A	N/A
No. of states, territories, and major metropolitan areas formally assessing public health capacity and preparedness	62	62	62	0
No. of states, territories, and other jurisdictions with access to the national secure, Epi-X	100	150	150	0
No. of public health professionals who use Epi-X to share intelligence regarding outbreaks and other emerging health events suggestive of terrorism	2100	3000	3000	0
No. of reports of disease outbreaks and other emerging health events posted each year on Epi-X	1200	1350	1400	50
Academic Centers for Public Health Preparedness	23	23	23	0
No. of laboratories qualified to provide surge capacity for analysis of chemical agents (in clinical specimens (blood, urine, etc.) only)	5	8	8	0
No. of local health departments developing advanced information technology in support of terrorism preparedness and response	5	5	5	0
Percent of state health departments that acknowledge receipt of Health Alert messages within 30 minutes of delivery 24/7.	60%	65%	70%	5%
Percent of state health departments that have interoperable redundant communication systems.	20%	25%	30%	5%
The percentage of fully-functional local health departments that have high speed continuous internet access and the ability to receive broadcast health alerts.	92%	95%	95%	0
Percent of state public health agencies that are prepared to use material contained in the SNS as demonstrated by evaluation of standard functions as determined by CDC	60%	70%	80%	10%
Percentage of LRN labs that pass proficiency testing for Category A and B threat agents	N/A	82%	N/A	N/A

OUTPUT TABLE	FY 2004 ACTUAL	FY 2005 APPROPRIATION	FY 2006 ESTIMATE	FY 2006 +/- FY 2005
Percent of state and local public health agencies that are compliant with CDC standards-based electronic disease surveillance systems for collection, analysis and reporting	N/A	34%	48%	14%
No. of laboratories to be inspected in accordance with the Select Agent Rule	300	525	600	75
No. of chemical terrorism agents that can be measured rapidly in human blood or urine using newly developed or recently improved methods	150	150	150	0
No. of laboratory procedures for Category A and Category B critical agents delivered by specialty laboratories for Laboratory Response Network use	20	33	N/A	N/A
No. of network and other partnerships who distribute or deliver CDC and PHTN training and education to target audiences.	10	10	10	0
No. of EIS Officers and mid-level epidemiologists (CEFOs) supported by terrorism funds and assigned to state and local health departments for public health emergency preparedness and response	67	67	67	0
No. of CDC professionals that are trained responders in the field	N/A	130	130	0
No. of internal and external response exercises conducted for radiological and chemical terrorist events	2	2	2	0
No. of state and local public health agencies in key jurisdictions that access BioSense data regularly to monitor for possible events	NA	44	55	11
No. of state veterinary and food safety laboratories brought into the LRN	10	15	15	0
No. of U.S. quarantine and border health stations at U.S. international airports and other selected ports of entry	8	18	25	7

FUNCTIONAL TABLE

Terrorism Budget by Functional Activity (Dollars in Thousands)	FY 2004 Actual	FY 2005 Enacted	FY 2006 Estimate	FY 2006 +/- FY 2005
Upgrading State & Local Capacity	\$918,454	\$926,736	\$797,138	(\$129,598)
Upgrading CDC Capacity	\$151,283	\$140,972	\$140,224	(\$748)
Anthrax	\$17,934	\$16,666	(\$0)	(\$16,666)
Biosurveillance Initiative	\$21,900	\$79,271	\$79,361	\$90
Strategic National Stockpile	\$397,640	\$396,800	\$600,000	\$203,200
Total -	\$1,507,211	\$1,560,445	\$1,616,723	\$56,278

INFLUENZA REPROGRAMMING AND TRANSFER

In FY 2005, up to \$37 million will be reprogrammed within and transferred to CDC for influenza related activities. Vaccine shortages during the 2004-2005 influenza season have highlighted the fragility of the influenza vaccine market and the need for its expansion and stabilization. To alleviate immediate shortages, CDC has been working in partnership across HHS to procure up to five million doses of investigational new drug (IND) influenza vaccine that is licensed for routine use in Canada and Europe. CDC has worked with FDA to identify possible supplies, negotiate with manufacturers, and set up a system for importing and distributing influenza vaccine as an IND. To date, CDC has purchased 1.2 million doses, and is assessing the need for additional procurements. CDC and HHS took extraordinary steps to locate vaccine and secure any available supplies. As a result, more people can be protected from influenza complications and lives can be saved.

To minimize the net cost of this procurement and its impact on Section 317 routine vaccination purchase, CDC and HHS have identified ways to help offset the use of these funds. HHS will transfer up to \$12.340 million from HRSA and ACF to offset the impact of this purchase.

In order to alleviate the impact of next year's influenza season, CDC is taking aggressive steps to ensure an expanded influenza supply to protect the nation. Maintaining an abundant influenza vaccine supply is critically important for protecting the public's health and improving our preparedness for an influenza pandemic. Based on the influenza vaccine shortage in the 2004-2005 influenza season, it is essential to add stability and strength to the U.S. influenza vaccine market. In response to this shortage CDC will enter into back-end sales guarantee contracts beginning in FY 2005 with reprogrammed funds, and these funds will expand in FY 2006 with an additional \$30 million for the Section 317 Immunization program requested in the President's Budget.

This back-end guarantee will be for bulk monovalent influenza vaccine. If supplies fall short, this bulk product can be turned into a finished trivalent influenza vaccine product for distribution. If supplies are sufficient, the bulk vaccine can be held until the following year's influenza season and developed into vaccines if the circulating strains remain the same. This back-end guarantee will help to expand the influenza market by adding guaranteed capacity to existing producers and perhaps serve as an enticement for additional manufacturers to enter the market.

REIMBURSEMENTS AND TRUST FUNDS

AUTHORIZING LEGISLATION

PHSA §§ 301, 306(b)(4), 353; Clinical Laboratory Improvement Act; User Fee: Labor-HHS FY Appropriations.

Reimbursements and Trust Funds (Dollars in Thousands)	FY 2004 Actual	FY 2005 Enacted	FY 2006 Estimate	FY 2006 +/- FY 2005
BA	\$568,769	\$625,015	\$630,271	\$5,256
FTE	1,472	1,472	1,472	0

STATEMENT OF THE BUDGET

The FY 2006 budget request of \$630,271,000 for Reimbursements and Trust Funds represents an increase of \$5,256,000 over the FY 2005 Enacted level of \$625,015,000.

PROGRAM DESCRIPTION

CDC's reimbursable activities provide technical assistance and consultation to other agencies and organizations. CDC has a long history of working and partnering with other Federal agencies in the shared interest of public health improvement and prevention programs.

CDC provides a wide range of support and assistance to other agencies. For instance, CDC is working with the United States Agency for International Development on various projects to support infectious disease and family planning. In another agreement, CDC is assisting the Department of Homeland Security in evaluating and assessing fire prevention grants to firefighters. CDC also works with the Department of Justice on the assessment of hand-held assays for threat agents. Also, CDC collaborates with the Environmental Protection Agency and the Federal Emergency Management Administration on several projects of public health concern.

CDC will continue its longstanding agreements with other agencies of the Public Health Service, HHS, and others associated with CDC's Health Statistics studies. CDC will continue to provide consultation and technical assistance in areas such as genetic diseases, laboratory tests, investigations and diagnostic reagents, development of worker safety guidance, and training and model screening programs.

The Clinical Laboratory Improvement Amendments of 1967 (CLIA) transferred responsibility for the laboratory licensure programs from CDC to HCFA, which resulted in the disbanding of CDC's regulatory staff. Under CLIA of 1988, the Secretary directed that the CLIA program be jointly implemented by HCFA and CDC. CDC will provide scientific/technical support related to patient test management, Quality Assurance / Quality Control, personnel requirements, and test categorization; develop information materials including brochures, a slide talk, and a user guide; develop and facilitate information education for newly regulated public health laboratories and clinics; and work with CMS to initiate a process for accrediting programs developed by nonprofit organizations and states to apply the CLIA standards.

The CDC program to implement the Federal Technology Transfer Act (FTTA) has three components: sharing research and materials, patenting inventions, and licensing inventions. CDC scientists have a long history of successful collaboration with scientists in private industry and other government agencies.

The FTTA allows government scientists to enter into formal agreements with scientists outside the government and in other government agencies. Two types of formal agreements are used for this purpose: Cooperative Research and Development Agreements (CRADA) and Biologic Materials Licensing Agreements. The FTTA gives preference to small businesses and to businesses producing products in the U.S. for the CRADA. Federal participants – individuals as well as organizations – can share patent rights and license fees for inventions made jointly under CRADAs.

RATIONALE FOR THE BUDGET

The FY 2006 budget request of \$630,271,000 for Reimbursements and Trust Funds represents an increase of \$5,256,000 over the FY 2005 Enacted level of \$625,015,000.

OUTPUT TABLE

OUTPUT TABLE	FY 2004 ACTUAL	FY 2005 APPROPRIATION	FY 2006 ESTIMATE	FY 2006 +/- FY 2005
Agency for International Development 11 Agreements for various projects, an infectious disease project, and family planning logistics.	N/A	\$57,708,550	\$57,708,550	\$0
Department of Agriculture 4 Agreements for various projects, National Nutrition Monitoring, NHANES 2002, to support active Surveillance Systems for bacterial diseases in the U.S.	\$7,821,983	\$1,685,000	\$1,685,000	\$0
Department of Commerce 2 Agreements for various projects, Develop Standards for Respiratory Protection Equipment and National Death Index Services.	\$5,570,771	\$3,506,120	\$3,506,120	\$0
Department of Defense 15 Agreements to perform various tasks such as Biowatch.	\$15,064,262	\$3,618,142	\$3,618,142	\$0
Department of Energy 7 Agreements for various projects including energy related analytical epidemiological research.	\$16,548,507	\$18,616,073	\$18,616,073	\$0
Department of Health and Human Services 116 Agreements to perform various projects, provide ongoing participation in the clinical laboratory improvement, develop questions for the National Health Interview Survey, and an estimated \$265,100,000 derived from evaluation funding under section 241 of the Public Health Service Act.	\$280,496,865	\$320,502,194	\$320,502,194	\$0
Department of Homeland Security 3 Agreements to evaluate and assess fire prevention grants to firefighters, and for National Pharmaceutical Stockpile and Smallpox activities.	N/A	\$14,534,501	\$14,534,501	\$0
Department of Housing and Urban Development 3 Agreements for Healthy Homes Initiatives, Lead-Based Paint Hazard Control, and inspections and risk assessments of project-based rental assisted housing.	\$3,296,816	\$2,978,122	\$2,978,122	\$0
Department of Interior 3 Agreements for various projects, Understanding of the Geography and Pathway of West Nile Virus, and for the Pacific Emergency Health Initiative.	\$326,774	\$246,872	\$246,872	\$0

NARRATIVE JUSTIFICATIONS
REIMBURSEMENTS AND TRUST FUNDS

OUTPUT TABLE	FY 2004 ACTUAL	FY 2005 APPROPRIATION	FY 2006 ESTIMATE	FY 2006 +/- FY 2005
Department of Justice For the evaluation of hand-held assays for threat agents.	\$1,915,000	\$1,132,884	\$1,132,884	\$0
Department of Labor 4 Agreements to perform various tasks, NIOSH response to Energy Employees Occupational Illness, and space commodities and support services.	\$28,983,619	\$55,768,000	\$55,768,000	\$0
Department of State 2 Agreements for Consultation and Assistance in Addressing Refugee Health Needs, for ICASS-IAG Working Group Chairperson, and Decontamination of State Annex 32.	\$49,425,357	\$273,711	\$273,711	\$0
Department of Transportation 2 Agreements for various projects including: carbon monoxide houseboats study and for a public health assessment	\$399,102	\$307,129	\$307,129	\$0
Environmental Protection Agency 7 Agreements for various projects including, health issues along the U.S./Mexican border, cost effectiveness measures, studies on occupational and environmental risks, and research of microbes on the Contaminant Candidate List.	\$2,503,433	\$567,160	\$567,160	\$0
Federal Emergency Management Administration 4 Agreements for health monitoring of response and recovery personnel in New York City.	\$90,000,000	\$86,571,310	\$86,571,310	\$0
Various Agencies 29 Agreements for various projects with various agencies	\$4,597,419	\$4,220,360	\$4,220,360	\$0

AGENCY FOR TOXIC SUBSTANCES AND DISEASE REGISTRY

AUTHORIZING LEGISLATION

The Comprehensive Environmental Response, Compensation, and Liability Act (CERCLA) of 1980 (as amended) §104(i); the 1984 amendments to the Resource Conservation and Recovery Act (RCRA) §3001; the Great Lakes Critical Programs Act of 1990; the 1990 amendments to the Clean Air Act; the Housing and Community Development (Lead Abatement) Act of 1992; the Defense Environmental Restoration Program.

Agency for Toxic Substances and Disease Registry (ATSDR) (Dollars in Thousands)	FY 2004 Actual	FY 2005 Enacted	FY 2006 Estimate	FY 2006 +/- FY 2005
BA	\$73,034	\$76,041	\$76,024	(\$17)
FTE	419	429	429	0

STATEMENT OF THE BUDGET

The FY 2006 budget request of \$76,024,000 for the Agency for Toxic Substances and Disease Registry represents a decrease of \$17,000 below the FY 2005 Enacted level of \$76,041,000.

PROGRAM DESCRIPTION

Since the discovery of contamination in New York State's Love Canal first brought the problem of hazardous wastes to national attention in the 1970s, thousands of hazardous sites have been identified around the country. The U.S. Environmental Protection Agency (EPA) has targeted more than 1,500 National Priorities List (NPL) sites for cleanup. ATSDR is the lead federal public health agency responsible for determining human health effects associated with toxic exposures, preventing continued exposures, and mitigating associated human health risks.

Formally organized in 1985, ATSDR was created by the Comprehensive Environmental Response, Compensation, and Liability Act of 1980 (CERCLA), more commonly known as the Superfund law. The Superfund program is responsible for finding and cleaning up the most dangerous hazardous waste sites in the country. ATSDR's role is to carry out parts of the Superfund law specifically related to human health, including health research, exposure investigations, and education.

ATSDR is headquartered in Atlanta, Georgia, and has ten regional offices. The agency's multidisciplinary staff includes epidemiologists, physicians, nurses, toxicologists, engineers, public health educators, and other specialists. In 2004, ATSDR and CDC's National Center for Environmental Health (NCEH) officially consolidated their Offices of the Director. The two public health agencies now share a management team and support staff under NCEH/ATSDR Director, Dr. Henry Falk. The Administrator of ATSDR and Director of CDC is Dr. Julie Louise Gerberding.

ATSDR's mission is to serve the public by using the best science, taking responsive public health actions and providing trusted health information to prevent harmful exposures and disease related exposures to toxic substances.

SAFEGUARDING COMMUNITIES

ATSDR helps communities cope with the uncertainties of living near hazardous waste sites or spills by providing the following types of health activities:

- Exposure investigations collect and analyze site information and perform biological tests, when appropriate, to determine whether people have been exposed to hazardous substances.
- Public Health Assessments (PHAs) review information about hazardous substances—such as lead, arsenic, mercury, or volatile organic compounds—found at a waste site. PHAs evaluate whether people living or working at the site or nearby may be exposed to harmful levels of these substances. To help keep the community safe, these assessments may advise EPA or other agencies to take certain actions, for instance, to institute blood tests for children or to remediate a waste site. ATSDR conducts a PHA for each site proposed for EPA's NPL of hazardous waste sites. ATSDR also assesses sites in response to petitions from communities.

NARRATIVE JUSTIFICATIONS
AGENCY FOR TOXIC SUBSTANCES AND DISEASE REGISTRY

- Health Consultations provide guidance on specific, health-related questions about hazardous wastes in communities. More limited in scope than PHAs, health consultations may be written or oral, and they may contain recommendations.
- Health Education programs offer information and training to affected communities and their medical professionals about ways to assess, control, or prevent exposure to hazardous substances in the environment.
- Health Studies help determine whether exposures to hazardous substances can lead to increased risk for various health problems, such as cancer, leukemia, multiple sclerosis, asthma, and other illnesses. ATSDR conducts its own health studies and supports those conducted by state health departments and universities.

Funding for ATSDR for the last five years:

FY	FUNDING
2001	\$74,835,000
2002	\$78,203,000
2003	\$82,262,000
2004	\$73,034,000
2005	\$76,041,000

FOR FURTHER INFORMATION, PLEASE REFER TO THE AGENCY FOR TOXIC SUBSTANCES AND DISEASE REGISTRY'S
FY 2006 CONGRESSIONAL JUSTIFICATION.

SUPPORTING INFORMATION

EXHIBIT P. STATE AND FORMULA GRANT PROGRAM TABLES

PREVENTIVE HEALTH AND HEALTH SERVICES BLOCK GRANT TABLE

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR DISEASE CONTROL AND PREVENTION				
FY 2006 DISCRETIONARY STATE/FORMULA GRANTS				
CFDA NUMBER/PROGRAM NAME: Preventive Health & Health Services Block Grant				
STATE/TERRITORY	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Estimate	Difference +/- 2005
Alabama	\$2,167,751	\$2,167,751	\$0	(\$2,167,751)
Alaska	\$472,255	\$472,255	\$0	(\$472,255)
Arizona	\$1,619,046	\$1,619,046	\$0	(\$1,619,046)
Arkansas	\$1,218,692	\$1,218,692	\$0	(\$1,218,692)
California	\$9,318,578	\$9,318,578	\$0	(\$9,318,578)
Colorado	\$1,685,041	\$1,685,041	\$0	(\$1,685,041)
Connecticut	\$1,980,801	\$1,980,801	\$0	(\$1,980,801)
Delaware	\$253,104	\$253,104	\$0	(\$253,104)
District of Columbia	\$1,059,653	\$1,059,653	\$0	(\$1,059,653)
Florida	\$4,058,059	\$4,058,059	\$0	(\$4,058,059)
Georgia	\$4,203,960	\$4,203,960	\$0	(\$4,203,960)
Hawaii	\$1,068,231	\$1,068,231	\$0	(\$1,068,231)
Idaho	\$504,715	\$504,715	\$0	(\$504,715)
Illinois	\$3,203,303	\$3,203,303	\$0	(\$3,203,303)
Indiana	\$2,289,060	\$2,289,060	\$0	(\$2,289,060)
Iowa	\$1,500,443	\$1,500,443	\$0	(\$1,500,443)
Kansas	\$1,242,015	\$1,242,015	\$0	(\$1,242,015)
Kentucky	\$1,829,304	\$1,829,304	\$0	(\$1,829,304)
Louisiana	\$3,977,051	\$3,977,051	\$0	(\$3,977,051)
Maine	\$1,222,661	\$1,222,661	\$0	(\$1,222,661)
Maryland	\$2,569,985	\$2,569,985	\$0	(\$2,569,985)
Massachusetts	\$3,709,242	\$3,709,242	\$0	(\$3,709,242)
Michigan	\$5,395,086	\$5,395,086	\$0	(\$5,395,086)
Minnesota	\$3,455,538	\$3,455,538	\$0	(\$3,455,538)
Mississippi	\$1,988,606	\$1,988,606	\$0	(\$1,988,606)
Missouri	\$3,403,248	\$3,403,248	\$0	(\$3,403,248)
Montana	\$905,427	\$905,427	\$0	(\$905,427)
Nebraska	\$2,238,645	\$2,238,645	\$0	(\$2,238,645)
Nevada	\$528,227	\$528,227	\$0	(\$528,227)
New Hampshire	\$1,955,432	\$1,955,432	\$0	(\$1,955,432)
New Jersey	\$3,943,089	\$3,943,089	\$0	(\$3,943,089)
New Mexico	\$1,920,088	\$1,920,088	\$0	(\$1,920,088)
New York	\$9,400,297	\$9,400,297	\$0	(\$9,400,297)
North Carolina	\$3,736,239	\$3,736,239	\$0	(\$3,736,239)
North Dakota	\$348,682	\$348,682	\$0	(\$348,682)

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR DISEASE CONTROL AND PREVENTION				
FY 2006 DISCRETIONARY STATE/FORMULA GRANTS				
CFDA NUMBER/PROGRAM NAME: <u>Preventive Health & Health Services Block Grant</u>				
STATE/TERRITORY	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Estimate	Difference +/- 2005
Ohio	\$6,185,082	\$6,185,082	\$0	(\$6,185,082)
Oklahoma	\$1,278,490	\$1,278,490	\$0	(\$1,278,490)
Oregon	\$980,266	\$980,266	\$0	(\$980,266)
Pennsylvania	\$6,514,683	\$6,514,683	\$0	(\$6,514,683)
Rhode Island	\$648,732	\$648,732	\$0	(\$648,732)
South Carolina	\$1,674,766	\$1,674,766	\$0	(\$1,674,766)
South Dakota	\$317,242	\$317,242	\$0	(\$317,242)
Tennessee	\$2,213,197	\$2,213,197	\$0	(\$2,213,197)
Texas	\$5,517,340	\$5,517,340	\$0	(\$5,517,340)
Utah	\$1,312,068	\$1,312,068	\$0	(\$1,312,068)
Vermont	\$372,971	\$372,971	\$0	(\$372,971)
Virginia	\$2,774,803	\$2,774,803	\$0	(\$2,774,803)
Washington	\$1,367,651	\$1,367,651	\$0	(\$1,367,651)
West Virginia	\$1,226,322	\$1,226,322	\$0	(\$1,226,322)
Wisconsin	\$2,670,512	\$2,670,512	\$0	(\$2,670,512)
Wyoming	\$310,332	\$310,332	\$0	(\$310,332)
Subtotal	\$125,736,011	\$125,736,011	\$0	(\$125,736,011)
Indian Tribes	\$81,497	\$81,497	\$0	(\$81,497)
Migrant Program	\$0	\$0	\$0	\$0
American Samoa	\$72,746	\$72,746	\$0	(\$72,746)
Guam	\$301,362	\$301,362	\$0	(\$301,362)
Marshall Islands	\$35,918	\$35,918	\$0	(\$35,918)
Micronesia	\$87,921	\$87,921	\$0	(\$87,921)
Northern Mariana Islands	\$55,426	\$55,426	\$0	(\$55,426)
Palau	\$28,952	\$28,952	\$0	(\$28,952)
Puerto Rico	\$2,138,703	\$2,138,703	\$0	(\$2,138,703)
Virgin Islands	\$238,324	\$238,324	\$0	(\$238,324)
Subtotal	\$3,040,849	\$3,040,849	\$0	(\$3,040,849)
Total States/Territories	\$128,776,860	\$128,776,860	\$0	(\$128,776,860)
Technical Assistance	\$3,037,140	\$1,982,140	\$0	(\$1,982,140)
State Penalties	-	-	-	-
Contingency Fund	-	-	-	-
Other Adjustments (specify)	-	-	-	-
Subtotal Adjustments	\$3,037,140	\$1,982,140	\$0	(\$1,982,140)
TOTAL RESOURCES	\$131,814,000	\$130,759,000	\$0	(\$130,759,000)

VACCINES FOR CHILDREN STATE-BY-STATE TABLE

DEPARTMENT OF HEALTH AND HUMAN SERVICES Centers for Disease Control and Prevention				
<u>FY 2006 MANDATORY (OR DISCRETIONARY) STATE/FORMULA GRANTS</u>				
CFDA NUMBER/PROGRAM NAME: Vaccines For Children Program - Proposed Law				
STATE/TERRITORY	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Estimate	Difference +/- 2005
Alabama	\$14,998,466	\$18,038,155	\$19,758,199	\$1,720,044
Alaska	\$4,698,606	\$5,650,857	\$6,189,699	\$538,843
Arizona	\$29,803,267	\$35,843,395	\$39,261,274	\$3,417,879
Arkansas	\$10,255,575	\$12,334,038	\$13,510,161	\$1,176,123
California	\$153,682,178	\$184,828,427	\$202,452,908	\$17,624,481
Colorado	\$15,792,860	\$18,993,546	\$20,804,692	\$1,811,147
Connecticut	\$8,852,834	\$10,647,008	\$11,662,263	\$1,015,255
Delaware	\$2,488,347	\$2,992,652	\$3,278,019	\$285,367
District of Columbia	\$2,710,439	\$3,259,755	\$3,570,591	\$310,837
Florida	\$52,646,310	\$63,315,960	\$69,353,511	\$6,037,550
Georgia	\$38,017,513	\$45,722,394	\$50,082,294	\$4,359,900
Hawaii	\$4,281,210	\$5,148,868	\$5,639,843	\$490,975
Idaho	\$5,957,491	\$7,164,876	\$7,848,089	\$683,213
Illinois	\$19,380,416	\$23,308,180	\$25,530,752	\$2,222,572
Indiana	\$13,926,368	\$16,748,778	\$18,345,873	\$1,597,095
Iowa	\$4,566,204	\$5,491,621	\$6,015,280	\$523,658
Kansas	\$6,298,845	\$7,575,411	\$8,297,771	\$722,360
Kentucky	\$13,436,475	\$16,159,600	\$17,700,513	\$1,540,913
Louisiana	\$15,086,476	\$18,144,001	\$19,874,139	\$1,730,138
Maine	\$3,637,337	\$4,374,504	\$4,791,639	\$417,135
Maryland	\$12,307,928	\$14,802,334	\$16,213,824	\$1,411,490
Massachusetts	\$15,071,451	\$18,125,931	\$19,854,346	\$1,728,414
Michigan	\$28,743,622	\$34,568,995	\$37,865,353	\$3,296,358
Minnesota	\$9,816,465	\$11,805,935	\$12,931,700	\$1,125,766
Mississippi	\$13,870,786	\$16,681,931	\$18,272,652	\$1,590,721
Missouri	\$13,859,210	\$16,668,009	\$18,257,402	\$1,589,393
Montana	\$2,711,178	\$3,260,643	\$3,571,565	\$310,922
Nebraska	\$4,688,876	\$5,639,155	\$6,176,881	\$537,727
Nevada	\$7,995,486	\$9,615,904	\$10,532,837	\$916,933
New Hampshire	\$4,037,337	\$4,855,570	\$5,318,578	\$463,007
New Jersey	\$18,619,301	\$22,392,812	\$24,528,099	\$2,135,287
New Mexico	\$9,717,954	\$11,687,459	\$12,801,927	\$1,114,468
New York	\$25,160,460	\$30,259,646	\$33,145,081	\$2,885,436
North Carolina	\$36,456,418	\$43,844,917	\$48,025,789	\$4,180,872
North Dakota	\$1,717,781	\$2,065,918	\$2,262,915	\$196,997

DEPARTMENT OF HEALTH AND HUMAN SERVICES Centers for Disease Control and Prevention				
FY 2006 MANDATORY (OR DISCRETIONARY) STATE/FORMULA GRANTS				
CFDA NUMBER/PROGRAM NAME: Vaccines For Children Program - Proposed Law				
STATE/TERRITORY	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Estimate	Difference +/- 2005
Ohio	\$26,606,156	\$31,998,336	\$35,049,566	\$3,051,230
Oklahoma	\$15,718,468	\$18,904,077	\$20,706,692	\$1,802,615
Oregon	\$11,314,052	\$13,607,033	\$14,904,544	\$1,297,511
Pennsylvania	\$18,029,740	\$21,683,767	\$23,751,442	\$2,067,675
Rhode Island	\$3,825,907	\$4,601,291	\$5,040,051	\$438,760
South Carolina	\$16,910,251	\$20,337,395	\$22,276,685	\$1,939,291
South Dakota	\$2,228,865	\$2,680,582	\$2,936,191	\$255,609
Tennessee	\$19,371,599	\$23,297,576	\$25,519,137	\$2,221,561
Texas	\$88,852,244	\$106,859,629	\$117,049,325	\$10,189,696
Utah	\$7,088,337	\$8,524,906	\$9,337,806	\$812,900
Vermont	\$2,109,037	\$2,536,468	\$2,778,336	\$241,867
Virginia	\$16,110,869	\$19,376,005	\$21,223,621	\$1,847,616
Washington	\$26,510,064	\$31,882,769	\$34,922,979	\$3,040,210
West Virginia	\$4,217,562	\$5,072,321	\$5,555,997	\$483,676
Wisconsin	\$8,603,789	\$10,347,490	\$11,334,184	\$986,694
Wyoming	\$2,106,488	\$2,533,403	\$2,774,978	\$241,575
Indian Tribes	-	-	-	-
Migrant Program	-	-	-	-
Chicago	\$17,726,386	\$21,318,933	\$23,351,819	\$2,032,886
Houston	\$956,753	\$1,150,655	\$1,260,377	\$109,722
New York City	\$34,154,469	\$41,076,440	\$44,993,321	\$3,916,881
Philadelphia	\$6,756,632	\$8,125,976	\$8,900,836	\$774,860
San Antonio	\$6,741,370	\$8,107,621	\$8,880,730	\$773,109
American Samoa	\$243,132	\$292,407	\$320,289	\$27,883
Guam	\$789,870	\$949,950	\$1,040,534	\$90,583
Marshall Islands	\$0	\$0	\$0	\$0
Micronesia	\$0	\$0	\$0	\$0
Northern Mariana Islands	\$225,749	\$271,501	\$297,390	\$25,889
Palau	\$0	\$0	\$0	\$0
Puerto Rico	\$13,144,790	\$15,808,800	\$17,316,263	\$1,507,462
Virgin Islands	\$1,458,359	\$1,753,920	\$1,921,166	\$167,247
Total States/Cities/Territories	\$977,092,408	\$1,175,116,433	\$1,287,170,718	\$112,054,285
Technical Assistance	-	-	-	-
State Penalties	-	-	-	-
Contingency Fund	-	-	-	-
Other Adjustments*	\$74,937,217	\$459,733,567	\$355,162,282	(\$104,571,285)
Subtotal Adjustments	\$74,937,217	\$459,733,567	\$355,162,282	(\$104,571,285)
TOTAL RESOURCES	\$1,052,029,625	\$1,634,850,000	\$1,642,333,000	\$7,483,000

*Adjustments include costs associated with vaccine stockpile purchases, storage and rotation, special projects and program support services.

EXHIBIT Q. DETAIL OF FULL-TIME EQUIVALENTS (FTEs)

FY 2006 BUDGET SUBMISSION CENTERS FOR DISEASE CONTROL AND PREVENTION DETAIL OF FTE EMPLOYMENT			
	FY 2004 Actual	FY 2005 Estimate	FY 2006 Request
Ceiling FTE			
Infectious Diseases	2,337	2,357	2,354
Health Promotion	831	804	821
Health Information and Service	632	611	611
Environmental Health and Injury	410	396	396
Occupational Safety and Health	1,287	1,244	1,246
Global Health	95	92	92
Public Health Research	7	7	7
Public Health Improvement and Leadership	875	846	846
Prev. Health & Health Services Block Grant	28	28	0
Business Services Support	1,180	1,142	1,143
Terrorism	538	582	582
Agency for Toxic Substances and Disease Registry	419	429	429
TOTAL, CEILING FTE	8,639	8,538	8,527
Statutory Exempt FTE			
Infectious Diseases	32	32	32
Health Promotion	2	2	2
Environmental Health and Injury	1	1	1
Global Health	20	20	20
Terrorism ¹	118	255	505
Total, Statutory Exempt FTE	173	310	560
TOTAL CDC/ATSDR FTE	8,812	8,848	9,087

¹ FTE levels for Terrorism include proposed increases for assigning additional FTEs to the state and local health departments in support of Homeland Security related activities. This increase will provide better technical assistance, better coordinated exercises and training across state boundaries, will create regional partnerships, will improve response capabilities, and help states achieve the new preparedness goals.

EXHIBIT R. DETAIL OF POSITIONS

PROGRAM ADMINISTRATION DETAIL OF POSITIONS			
	2004 Actual	2005 Appropriation	2006 Estimate
Executive Level			
Executive level I	-	-	-
Executive level II	-	-	-
Executive level III	-	-	-
Executive level IV	-	-	-
Executive level V	-	-	-
<i>Subtotal</i>	-	-	-
Total-Executive Level Salary	-	-	-
<i>Total - SES</i>	23	23	23
Total - SES Salary	\$3,258,546	\$3,388,888	\$3,524,443
GS-15	398	398	398
GS-14	1,161	1,161	1,161
GS-13	1,958	1,958	1,958
GS-12	1,203	1,203	1,203
GS-11	748	748	748
GS-10	26	26	26
GS-9	596	596	596
GS-8	105	105	105
GS-7	467	467	467
GS-6	139	139	139
GS-5	101	101	101
GS-4	57	57	57
GS-3	17	17	17
GS-2	4	4	4
GS-1	3	3	3
<i>Subtotal</i>	<i>6,983</i>	<i>6,983</i>	<i>6,983</i>
Total - GS Salary	\$506,380,974	\$526,636,213	\$547,701,661
Average GS grade	11.7	11.7	11.7
Average GS salary	72,516	75,417	78,434
Average Special Pay Categories			
Average Comm. Corps Salary ¹	89,371	92,945	96,663
Average Wage Grade Salary	48,818	50,770	52,801

¹ Includes special pays and allowances.

EXHIBIT S. NEW POSITIONS REQUESTED

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR DISEASE CONTROL AND PREVENTION NEW POSITIONS REQUESTED			
	FY 2005 Appropriation	FY 2006 Estimate	FY 2006 +/- FY 2005
Exempt	250	500	250
Non-Exempt	529	529	0
Total obligations	779	1,029	250

EXHIBIT T. BUDGET AND PERFORMANCE CROSSWALK

Budget and Performance Crosswalk (Dollars in thousands)				
Performance Program Area (PPA)	Budget Activity	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Estimate
Infectious Diseases	Infectious Diseases	1,654,394	1,665,330	1,609,758
Health Promotion	Health Promotion	932,067	1,024,033	964,421
Health Information and Service	Health Information and Service	210,516	228,673	223,799
Environmental Health and Injury	Environmental Health and Injury	282,925	285,721	284,820
Occupational Safety and Health	Occupational Safety and Health	276,988	286,041	285,930
Global Health	Global Health	285,983	293,863	306,079
Public Health Research	Public Health Research	29,107	31,000	31,000
Public Health Improvement & Leadership	Public Health Improvement & Leadership	232,824	266,843	206,541
Prev. Health & Health Services Block Grant	Prev. Health & Health Services Block Grant	131,814	130,759	0
Buildings and Facilities	Buildings and Facilities	260,454	269,708	30,000
Business Services and Support	Business Services and Support	282,226	278,840	263,715
Agency for Toxic Substance and Disease Registry	Agency for Toxic Substance and Disease Registry	73,034	76,041	76,024
Terrorism	Terrorism	1,507,211	1,560,445	1,616,723
	OPDIV Total Request	\$6,159,542	\$6,397,297	\$5,898,810

EXHIBIT U. DETAIL OF PERFORMANCE ANALYSIS

The legend below provides detail for the icons referenced within the Detail of Performance Tables.

DETAIL OF PERFORMANCE LEGEND	
E	Efficiency Measure
HHS#	HHS Strategic Plan Goal
HP#	Healthy People 2010 Objective
O	Outcome Measure
PAR	Performance and Accountability Report
PART	Program Assessment Rating Tool
 #	President's Management Agenda Initiative

INFECTIOUS DISEASES

INFECTIOUS DISEASES CONTROL

The Infectious Diseases Control program participated in the Program Assessment Rating Tool (PART) for the FY 2006 budget cycle. This document reflects the additional measures adopted as a result of the PART process. While some measures may seem redundant, there are slight variations in what or how an outcome is being measured. The PART measures are ambitious and will become a permanent element of this performance plan. These measures are identified in the reference column as PART and are generally located at the end of a goal area. In addition, as previous GPRA measures and goals are retired, the program will use one overarching goal – To Protect Americans from Infectious Diseases – and lessen the categorical nature of this plan.

EFFICIENCY MEASURE	TARGETS	ACTUAL PERFORMANCE	REF.
1. Increase access to health information for international travel with the same funding. [E]	FY 2005: 5% FY 2004: Establish Baseline	FY 2005: 12/2006 FY 2004: 5,557,811 website visits (Baseline)	HHS-8
2. Enhance detection and control of foodborne outbreaks by increasing the number of foodborne isolates identified, fingerprinted, and electronically submitted to CDC's computerized national database networks with annual level funding. [E]	FY 2006: 24,866 isolates FY 2005: 21,471 isolates FY 2004: 17,876 isolates	FY 2006: 12/2007 FY 2005: 12/2006 FY 2004: 12/2005 FY 2003: 14,864 (Baseline)	HHS-8, PART

Efficiency Measure 1:

With the introduction of new technology, most notably the Internet, CDC has dramatically reduced the number of staff hours required to respond to inquiries surrounding travelers' health. In 1995, there were over 60,000 live phone calls (in addition to sending 177,000 responses to the automated fax system and 181,000 uses of the ATT voice system) and only 137,000 hits to the travelers' health website. By 2000, the number of phone calls, automated faxes, and uses of the ATT voice system had dropped dramatically (less than 4,000 phone calls, 41,000 automated faxes and 72,000 uses of the ATT voice system), while there were over 2.5 million visits to the travelers' health website. From July 2003 through June 2004, there were 5,220 direct phone calls, e-mails and letters, and approximately 5.5 million visits for the travelers' health website. This measure will be retired after data are reported FY 2005.

Efficiency Measure 2:

PulseNet is an early warning system for outbreaks of foodborne disease. It is a national network of public health laboratories that performs DNA fingerprinting on bacteria that may be foodborne. CaliciNet is a similar DNA fingerprinting network for Norovirus. These networks identify and label each disease-causing organism by its fingerprint pattern and rapidly compare new patterns to those existing in the electronic database at CDC to identify related strains. The DNA fingerprinting can distinguish strains of disease-causing organisms such as Escherichia coli, Salmonella, Shigella, Listeria and Norovirus, thus allowing early detection of disease clusters.

Currently, databases are available for E. coli, Salmonella, Listeria monocytogenes, Shigella, Campylobacter, and Norovirus. CDC will increase the number of online submissions during 2004 – 2007 by increasing the number of individuals at the participating laboratories who are certified to electronically submit PFGE patterns directly to the database.

PROTECT AMERICANS FROM INFECTIOUS DISEASES

GOAL 1: PROTECT AMERICANS FROM INFECTIOUS DISEASES – HEPATITIS C, CHRONIC LIVER DISEASE, AND VIRAL HEPATITIS.			
Performance Measure	Targets	Actual Performance	Ref
1. Provide support to up to 65 health departments for coordinators to initiate hepatitis prevention and control activities.	FY 2005: 50 health departments FY 2004: 50 health departments FY 2003: 48 health departments	FY 2005: 9/2005 FY 2004: 52 (Exceeded) FY 2003: 50 (Exceeded)	HHS-1, 4, HP-14.9

GOAL 1: PROTECT AMERICANS FROM INFECTIOUS DISEASES – HEPATITIS C, CHRONIC LIVER DISEASE, AND VIRAL HEPATITIS.			
Performance Measure	Targets	Actual Performance	Ref
2. By 2010, reduce the number of new cases of hepatitis A to 2.25 new cases per 100,000 population. [O]	FY 2006: 2.6 new cases FY 2005: 2.6 new cases	FY 2006: 12/2006 FY 2005: 12/2005 FY 1997: 11.3 (Baseline)	HHS-1, PART

Goal 1, Performance Measure 1:

To date, CDC has exceeded the targeted number of health departments to receive funding. In FY 2004, CDC funded two additional coordinators through the prudent management of hepatitis program funds. Hepatitis C coordinators in state and local health departments help initiate and integrate hepatitis prevention activities in existing public health programs (e.g., HIV and STD prevention, immunization, epidemiology, and surveillance) in various settings. They also develop and provide educational programs and materials. This measure will be retired after data are reported for FY 2005.

Goal 1, Performance Measure 2:

CDC is on track to achieve the long-term target for hepatitis A. Overall hepatitis A rates have declined dramatically (>78 percent) since the last nationwide outbreak in 1995. The Healthy People 2010 target for reducing hepatitis A rates (4.5 new cases per 100,000 population) was achieved in 2001. The rate in 2003 (2.6 new cases per 100,000) is the lowest rate recorded since surveillance for hepatitis A began in 1966. This precipitous decline in hepatitis A rates has coincided with the implementation of the HHS Advisory Committee on Immunization Practices (ACIP) recommendations for use of hepatitis A vaccine for the prevention and control of hepatitis A. In particular, in 1999, ACIP recommended routine vaccination of children living in 11 states which had consistently elevated hepatitis A rates during the previous decade (1987-1997) and suggested that it be considered in another six states. Comparing 2003 rates to the average rates during 1987-1997, the rate in these 17 states declined 89 percent (22.3 to 2.5 per 100,000 population) but only by 52 percent elsewhere (5.6 to 2.7 per 100,000 population). Cases occurring in these states accounted for more than 65 percent of national cases during 1987-1997, but represented only 33 percent of cases in 2003. Declines in rates have been greater in the regions and age groups where routine hepatitis A vaccination for children has been recommended, strongly suggesting that the reductions in rates are attributable to the current vaccine strategy. Although increases in rates may still occur, it is expected that the downward trend in rates will continue with ongoing implementation of the ACIP vaccination strategy.

GOAL 2: PROTECT AMERICANS FROM INFECTIOUS DISEASES – INFLUENZA.			
Performance Measure	Targets	Actual Performance	Ref
1. Monitor influenza viruses in states (1 site/250,000 population domestically) and support influenza surveillance sites and networks internationally to enhance early detection of viruses with pandemic potential and improve vaccine decision-making.	FY 2005: 1,000 sites/9 networks FY 2004: 800 sites/2 networks FY 2003: 750 sites/1 network	FY 2005: 9/2005 FY 2004: 1,004/9 (Exceeded) FY 2003: 891/1 (Exceeded)	HHS-1, 4, HP-14.1
2. By 2010 enhance preparedness for pandemic influenza by establishing in-country influenza networks that are actively producing usable samples for testing as measured by geographic and population coverage.	FY 2006: 9 networks; 70-100% geographic coverage and 70% population coverage per country network FY 2005: 9 networks; 70-100% geographic coverage and 70% population coverage per country network	FY 2006: 12/2006 FY 2005: 12/2005	HHS-4, 5, PART

GOAL 2: PROTECT AMERICANS FROM INFECTIOUS DISEASES – INFLUENZA.			
Performance Measure	Targets	Actual Performance	Ref
		<p>FY 2004: 9 networks; 1 with 100% geographic coverage and 70% population coverage; 8 with 10-40% geographic coverage and 10-40% population coverage per country network.</p> <p>FY 2003: 1 network; 60% geographic coverage; and, 60% population coverage per country network (Baseline)</p>	

Goal 2, Performance Measure 1:

CDC has improved preparedness for both epidemics and a possible pandemic of influenza by expanding influenza surveillance. To date, CDC has exceeded the number of targeted domestic sites through recruitment of U.S. sentinel physicians and follow-up by CDC staff to ensure constant reporting. Therefore, targets continue to be revised upward. These domestic and international sites provide surveillance data that are critical to influenza vaccine decisions. In FY 2004, CDC embarked on a major initiative to enhance international surveillance particularly in countries affected by avian influenza viruses. Bilateral cooperative agreements were awarded to nine countries affected by avian influenza to enhance or develop influenza surveillance networks. These grants will allow better geographic representation of circulating influenza viruses, enhance the “early warning system” for detection of novel strains, and contribute to vaccine strain selection. CDC will continue to build capacity for influenza surveillance sites and networks internationally. These international networks strengthen global surveillance capabilities to increase the likelihood of early detection of an influenza pandemic and effective tracking of its spread. They also provide critical information needed to improve vaccine decision-making.

Improving U.S. sentinel physician surveillance is a priority because it is the primary system for measuring annual influenza morbidity and is a source for measuring the potential impact of an influenza pandemic in the U.S. Data collected about circulating influenza viruses are used to form the basis for annual vaccine decisions. This measure will be retired after data are reported for FY 2005.

Goal 2, Performance Measure 2:

This measure will track CDC’s efforts to increase the number of influenza networks in Asia to enhance early detection of viruses with pandemic potential and improve vaccine decision making. Early detection of pandemic viruses will benefit the international community by allowing the maximum lead time possible to develop pandemic vaccines, thus reducing morbidity and mortality globally. The accomplishment of this measure will also establish the influenza surveillance foundation necessary to conduct influenza burden studies, formulate vaccine policy, and reduce illness due to influenza through vaccination. Ideally, a network will be a nationwide system developed to collect virologic and epidemiologic data for influenza by establishing five or more sites with good distribution throughout the country. Each site will consist of a local laboratory and one or more clinics of hospitals for data collection. However, some flexibility of this definition may be needed based on geographic and resource considerations.

Currently, CDC supports one influenza surveillance network in China through a cooperative agreement with the Western Pacific Region of the World Health Organization (WHO) in Manila. The agreement supported 23 sites in the past with plans to include 31 sites in the future. Support is provided through on-site training, the provision of technical assistance and funding through WHO for equipment and supplies. As part of the overall plan to develop networks in Asia, key staff will be located in Asia, and CDC will provide technical assistance and support for enhancing or developing influenza surveillance networks. In addition, CDC has announced intentions to provide support and assistance to foreign governments to establish additional networks.

GOAL 3: PROTECT AMERICANS FROM INFECTIOUS DISEASES – FOODBORNE ILLNESSES.					
Performance Measure	Targets	Actual Performance	Ref		
1. Expand the number of public health laboratories using PulseNet for early identification of and response to foodborne disease outbreaks (number of agents may increase as new pathogens are identified).	E. coli 0157:H7 FY 2005: 45 labs FY 2004: 45 labs FY 2003: 45 labs	E. coli 0157:H7 FY 2005: 9/2005 FY 2004: 45 (Met) FY 2003: 45 (Met)	HHS-2, HP-10.2		
	Salmonella Typhimurium FY 2005: 45 labs FY 2004: 45 labs FY 2003: 45 labs	Salmonella Typhimurium FY 2005: 9/2005 FY 2004: 45 (Met) FY 2003: 45 (Met)			
	Listeria monocytogenes FY 2005: 30 labs FY 2004: 30 labs FY 2003: 30 labs	Listeria monocytogenes FY 2005: 9/2005 FY 2004: 30 (Met) FY 2003: 30 (Met)			
	Shigella sonnei FY 2005: 15 labs FY 2004: 15 labs FY 2003: 15 labs	Shigella sonnei FY 2005: 9/2005 FY 2004: 15 (Met) FY 2003: 15 (Met)			
	Clostridium perfringens FY 2005: 5 labs FY 2004: 3 labs FY 2003: 0 lab	Clostridium perfringens FY 2005: 9/2005 FY 2004: 3 (Met) FY 2003: 0 (Baseline)			
	Campylobacter jejuni/C. coli FY 2005: 5 labs FY 2004: 5 labs FY 2003: 0 lab	Campylobacter jejuni/C. coli FY 2005: 9/2005 FY 2004: 5 (Met) FY 2003: 0 (Baseline)			
	Vibrio parahaemolyticus FY 2005: 5 labs FY 2004: 5 labs FY 2003: 0 lab	Vibrio parahaemolyticus FY 2005: 9/2005 FY 2004: 5 (Met) FY 2003: 0 (Baseline)			
	Vibrio cholerae FY 2005: 5 labs FY 2004: 5 labs FY 2003: 0 labs	Vibrio cholerae FY 2005: 9/2005 FY 2004: 5 (Met) FY 2003: 0 (Baseline)			
	2. Enhance FoodNet by increasing the number of pathogens and syndromes under active surveillance.	FY 2005: 11 pathogen/syndrome FY 2004: 11 pathogen/syndrome FY 2003: 11 pathogen/syndrome		FY 2005: 9/2005 FY 2004: 11 (Met) FY 2003: 11 (Met)	HHS-2, HP-10.2
	3. By 2010, reduce the incidence and infection with four key foodborne pathogens by 50%. [O]	Campylobacter FY 2006: 16.10 FY 2005: 17.03		Campylobacter FY 2006: 12/2006 FY 2005: 12/2005	HHS-1, PART
		Escherichia Coli 0157:H7 FY 2006: 1.30 FY 2005: 1.42		Escherichia Coli 0157:H7 FY 2006: 12/2006 FY 2005: 12/2005	
		Listeria monocytogenes FY 2006: 0.33 FY 2005: 0.35		Listeria monocytogenes FY 2006: 12/2006 FY 2005: 12/2005	

GOAL 3: PROTECT AMERICANS FROM INFECTIOUS DISEASES – FOODBORNE ILLNESSES.			
Performance Measure	Targets	Actual Performance	Ref
	Salmonella species FY 2006: 8.90 FY 2005: 9.45	Salmonella species FY 2006: 12/2006 FY 2005: 12/2005	

Goal 3, Performance Measure 1:

CDC and its state partners designed and implemented the PulseNet DNA fingerprinting network in public health laboratories to provide early detection and investigation of foodborne disease outbreaks within and between states. CDC has prioritized the expansion of PulseNet because of the increased demand from participating sites. As of FY 2004, the targets for each of the pathogens were met. This measure will be retired after data are reported for FY 2005.

Goal 3, Performance Measure 2:

CDC led the development and implementation of FoodNet, a network of 11 sentinel sites, which provides accurate trend information for important foodborne infections and improved methods for early detection of foodborne disease problems within and between states. These programs and other CDC efforts have accomplished the following results:

- Strengthened and expanded the tracking system for foodborne illness.
- Improved and expanded pathogen-detection methods.
- Improved techniques to avoid, reduce, and eliminate pathogens.
- Improved outbreak containment.

In FY 2004, CDC met its target of increasing the number of pathogens and syndromes under active surveillance with eight common bacterial pathogens, two parasites, and one syndrome (Hemolytic Uremic Syndrome) under active surveillance. In FY 2000, using FoodNet and other sources, CDC updated estimates of the burden of foodborne disease in the U.S. These estimates indicate that 76 million cases of foodborne illnesses result in 325,000 hospitalizations and 5,000 deaths annually.

A recent summary of FoodNet data from 1996–2003 showed significant declines in rates of infection with *Yersinia enterocolitica* (49 percent decline between 1996 and 2003), *E. coli* O157 (42 percent), *Salmonella* (17 percent), and *Cryptosporidium* (51 percent), suggesting the current efforts to reduce these diseases are on track towards the Healthy People 2010 objectives. Rates of infection with *Listeria monocytogenes* declined each year from 1996 to 2002, increased slightly in 2003, but today remains below the 1996 baseline. New interagency efforts in research and surveillance to improve and document the effectiveness of food safety measures are underway. This measure will be retired after data are reported for FY 2005.

Goal 3, Performance Measure 3:

Annual data on the incidence rates of infection with *Campylobacter* species, *Escherichia coli* O157:H7, and *Salmonella* indicate that CDC is on track to meet its annual targets for 2005 in this area. *Listeria* presents more of a challenge. However, *Listeria* infections may decline after full implementation of the national *Listeria* Action Plan. This plan is a joint effort between FDA and CDC to reduce *Listeria* cases through efficient risk management, by empowering consumers, and improving consumer safety.

GOAL 4: PROTECT AMERICANS FROM INFECTIOUS DISEASES – GROUP B STREPTOCOCCAL INFECTIONS.			
Performance Measure	Targets	Actual Performance	Ref
1. Reduce the incidence of perinatal group B streptococcal infections to 0.3 per 1,000 live births. [O]	FY 2004: 0.3 FY 2003: 0.3 FY 2002: 0.3	FY 2004: 3/2005 FY 2003: 0.32 (Met) FY 2002: 0.42 (Unmet)	HHS-1

Goal 4, Performance Measure 1:

CDC met the FY 2003 target to reduce the incidence of perinatal group B streptococcal (GBS) infections to 0.3 per 1,000 live births. However, rates vary by ethnic groups. Whites: 0.26; Blacks: 0.59; Hispanics: 0.31; and other races: 0.16. After a plateau in early-onset GBS disease incidence from 1999-2002, rates dropped by 34 percent in 2003

following the release of universal prenatal screening guidelines. CDC met the FY 2003 target for the overall rate of perinatal disease, and approached or achieved the target for major racial and ethnic groups except blacks. The rate of disease in blacks decreased by 31 percent following release of new prevention guidelines suggesting that full implementation of universal prenatal screening may lead to achievement of the target for black infants in future years. This measure will be retired after data are reported for FY 2004.

ANTIMICROBIAL RESISTANCE

GOAL 5: REDUCE THE SPREAD OF ANTIMICROBIAL RESISTANCE.			
Performance Measure	Targets	Actual Performance	Ref
1. Diminish the rapid rise in the proportion of enterococci resistant to vancomycin (VRE rate) among pathogens associated with nosocomial infections in ICU patients. [O]	FY 2003: 26%	FY 2003: 11.8% (Exceeded)	HHS-1, HP-14.21
2. Reduce the number of courses of antibiotics for ear infections for children < 5 years to 57 courses per 100 children. [O]	FY 2005: 62 courses FY 2004: 62 courses FY 2003: 63 courses	FY 2005: 9/2006 FY 2004: 9/2005 FY 2003: 2/2005	HHS-1, HP-14.18
3. Increase the proportion of U.S. laboratories that use acceptable methods to test for <i>Staphylococcus aureus</i> with reduced susceptibility to vancomycin.	FY 2004: 95% FY 2003: 90% FY 2002: 85%	FY 2004: 99% (Exceeded) FY 2003: 91% (Exceeded) FY 2002: Data unavailable	HHS-4
4. Reduce the number of courses of antibiotics prescribed for a sole diagnosis of the common cold to 1,268 courses per 100,000 population. [O]	FY 2005: 1,917 courses FY 2004: 1,917 courses FY 2003: 2,017 courses FY 2002: 2,144 courses	FY 2005: 9/2006 FY 2004: 9/2005 FY 2003: 2/2005 FY 2002: 1,913 (CY 2001) (Exceeded)	HHS-1, HP-14.19
5. Decrease the number of antibiotics prescribed for ear infections in children under 5 years of age per 100 children. [O]	FY 2006: 60 courses FY 2005: 61 courses	FY 2006: 12/2006 FY 2005: 12/2005	HHS-4, 5, HP-14.18, PART

Goal 5, Performance Measure 1:

The target to diminish the rapid rise in the proportion of VRE rate among pathogens associated with nosocomial infections in ICU patients has been exceeded. The rate of increase per year in the proportion of VRE has slowed, resulting in only a 10.5 percent increase over the five-year historical mean. This is below the target of a 26 percent increase, suggesting that infection control measures implemented in U.S. hospitals may be effective in slowing the rate of increase. Continued efforts to reduce the prevalence of VRE are ongoing. This measure will be retired after data are reported for FY 2003.

Goal 5, Performance Measure 2:

The number of courses of antibiotics given for ear infections to children under five years of age rose from 59 in 2000 to 60 in 2001. The difference is largely due to the survey design used to collect the data and is not statistically significant. Future reductions in antibiotic prescriptions for otitis media will hinge on increasing awareness of the public health problem of antimicrobial resistance, maintaining effective national efforts including the CDC's education campaigns targeted to physicians and the public on judicious use of antibiotics, or on a decrease in the incidence of otitis media. This measure will be retired after data are reported for FY 2005.

Goal 5, Performance Measure 3:

The capacity of laboratories in the U.S. to detect emerging vancomycin resistance in *Staphylococcus aureus*, including vancomycin-intermediate *Staphylococcus aureus* (VISA) and vancomycin-resistant *Staphylococcus aureus* (VRSA), is improving. Data for this measure is obtained through laboratory surveys. In FY 2004, 99 percent of U.S. laboratories had the capacity to detect VISA and VRSA. This increased capacity over previous years is likely due to increased awareness of the problem by laboratory-based microbiologists through several educational efforts by CDC

including a CD-ROM-based training program on Antimicrobial Susceptibility Testing (distributed by CDC and the Association of Public Health Laboratories), CDC's MASTER website on Antimicrobial Susceptibility Testing, several articles in MMWR, and a series of publications in the peer-reviewed literature that are highlighted in CDC-sponsored training workshops on susceptibility testing. This measure will be retired after data are reported for FY 2004.

Goal 5, Performance Measure 4:

Because the common cold is caused by a virus, antibiotic therapy is ineffective in treating these infections. Reducing the use of antibiotics in the treatment of the common cold remains one of the prime targets of CDC's antimicrobial resistance campaign. Although prescribing antibiotics for the common cold rose from 1,770 courses per 100,000 population in 2000 to 1,913 courses per 100,000 population in 2001 (calendar year), this difference is largely due to the survey design used to collect that data and is not statistically significant. CDC exceeded its FY 2002 target, and will continue to monitor future progress. Success in exceeding this measure may reflect efforts by CDC and partners to promote appropriate antibiotic use in the community. This measure will be retired data after data are reported for FY 2005.

Goal 5, Performance Measure 5:

Performance data indicate that CDC is on track to meet its FY 2005 annual target of 61 courses of antibiotics per 100 children. Data show that antibiotic ear infection prescriptions for children under five have declined to 63 courses per 100 children, compared to the 1997 baseline of 69 courses.

CDC's public health campaign "Get Smart: Know When Antibiotics Work" is focused on this measure. The campaign involves an alliance of partners working to reduce inappropriate antibiotic use and reduce the spread of resistance to antibiotics. This national campaign includes a series of television, radio, and print public service announcements and comprehensive national, state, and local outreach. For example, in September 2003, CDC launched a national ad campaign created to promote appropriate antibiotics use knowledge among parents, which generated over 90 million audience impressions through television, print, and online media. Other current campaign activities include funding states (a total of 29 in 2003) to develop, implement, and evaluate local campaigns and evaluating and promoting a medical school curriculum on appropriate use of antibiotics. In addition, this year the National Committee for Quality Assurance's Health Plan Employer Data and Information Set (HEDIS) will include two measures on appropriate antibiotic use that were through the campaign.

In May 2004, the American Academy of Pediatrics and the American Academy of Family Physicians issued new guidelines for the management of ear infections. These guidelines present an option of observing selected children with ear infections without prescribing an antibiotic. CDC expects that as these guidelines are implemented, prescribing for ear infections will decline, accelerating their movement towards achieving this goal.

MEDICAL ERRORS AND HEALTHCARE-ASSOCIATED INFECTIONS

GOAL 6: PROTECT AMERICANS FROM DEATH AND SERIOUS HARM CAUSED BY MEDICAL ERRORS AND PREVENTABLE COMPLICATIONS OF HEALTHCARE.			
Performance Measure	Targets	Actual Performance	Ref
1. Reduce the rate of central line-associated bloodstream infections in adult ICU patients to 3.8. [O]	FY 2005: 3.8 FY 2004: 3.8 FY 2003: 3.8 FY 2002: 3.8	FY 2005: 4/2006 FY 2004: 4/2005 FY 2003: 4.0 (Unmet) FY 2002: 4.3 (Unmet)	HHS-1, 5
2. By 2010, reduce the rate of central line associated bloodstream infections by 10%. [O]	FY 2006: 3.55 FY 2005: 3.58 FY 2004: 3.62	FY 2006: 12/2006 FY 2005: 12/2005 FY 2004: 3.6 (Met) FY 2003: 3.7 (Baseline)	HHS-1, 5, PART

Goal 6, Performance Measure 1:

The FY 2003 target for reducing central line-associated bloodstream infections was unmet. This is consistent with the growing magnitude of the patient safety problem in the U.S., especially with regard to healthcare-associated infections. Possible reasons for this reported increase include:

- The increasing severity of illness of patients in hospital ICUs.
- The national nursing shortage, which makes it more difficult to hire and retain well-trained staff and maintain favorable nurse to patient ratios.
- The continuing rise in the number of antimicrobial-resistant infections that are harder to treat.

These data reinforce the importance of implementing NHSN as part of the HHS patient safety data system. It also underscores the need for aggressive programs to control and reduce antimicrobial resistance in hospitals and the need to address the broader problem of hospital-acquired infections in the context of the HHS patient safety initiatives that are now underway. CDC is actively collaborating with public and private sector partners to help bring about the changes that will lead to a redesigned, safer, and more effective healthcare system. This measure will be retired data after data are reported for FY 2005.

Goal 6, Performance Measure 2:

This measure uses data from combined medical/surgical intensive care units (ICUs) from hospitals not designated as major teaching facilities because this is the most prevalent unit reported in NNIS and thus most representative. From 2003 to 2004, the rate of central-line associated bloodstream infections in medical/surgical ICUs in non-major teaching hospitals decreased from 3.7 to 3.6.

GOAL 7: PROTECT AMERICANS FROM INFECTIOUS DISEASES - PNEUMOCOCCAL DISEASE.			
Performance Measure	Targets	Actual Performance	Ref
1. By 2010, reduce the rates of invasive pneumococcal disease in children under 5 years of age to 46 per 100,000 and in adults aged 65 years and older to 42 per 100,000. [O]	Children under 5 years of age FY 2006: 48 FY 2005: 50 Adults 65 years and older FY 2006: 47 FY 2005: 55	Children under 5 years of age FY 2006: 12/2006 FY 2005: 12/2005 Adults 65 years and older FY 2006: 12/2006 FY 2005: 12/2005	HHS-1, HP-14.5, PART

Goal 7, Performance Measure 1:

Incidence of pneumococcal disease fell between 2001 and 2002. These data indicate that CDC is on track to reach disease reduction targets. Progress is aided by the introduction of the new pneumococcal conjugate vaccine that was licensed for use in children in the U.S. in 2000. Vaccinating children has reduced disease in adults through reduced transmission. However, some challenges remain. Supplies of the conjugate vaccine have been inadequate for much of the time since licensure. CDC has been working with the vaccine manufacturer, CDC's Advisory Committee on Immunization Practices, and professional organizations to promote optimal and equitable use of vaccine during times of shortage.

GOAL 8: PROTECT AMERICANS FROM INFECTIOUS DISEASES - LABORATORY RESPONSE.			
Performance Measure	Targets	Actual Performance	Ref
1. Increase the percentage of Laboratory Response Network labs with cumulative proficiency testing scores of 90% or better.	FY 2006: 84% of labs FY 2005: 80% of labs	FY 2006: 12/2006 FY 2005: 12/2005 FY 2004: 79% (Baseline)	HHS-4, 5, PART

Goal 8, Performance Measure 1:

The purpose of proficiency testing (PT) is to determine if LRN laboratories are continuously able to accurately identify the biological agents that may appear in naturally-occurring outbreaks or that may be used as agents of bioterrorism by using the instruments and protocols employed by the LRN. CDC provides a special PT program to each LRN laboratory that is, in turn, required to successfully participate. With each event, the PT program sends one or more select agents to each laboratory as pure cultures, genetic fragments, or substances embedded in a sample matrix mimicking an environmental powder or other sample. Laboratories are challenged to provide the correct genus and species answer using the established protocols within a limited and specified time frame. The cumulative PT score for a year is calculated by averaging the scores from each quarterly PT from each test site and then at the end of the year, calculating a national average from the total number of sites that participate in the program.

The PT program has been in place since the LRN was initiated in 1999. At the onset of the program, very few state laboratories had the ability to rapidly and accurately identify biological and select agents. Because of the difficulty in identifying certain select agents and because of logistics issues, the success rate in 2003 was about 75 percent. In order to achieve a goal of a cumulative average of 90 percent or greater for all labs in the LRN, it is necessary to maintain constant communication regarding the standard operating plan regarding specimen analysis, to provide updates on protocols, to provide remediation and training to those laboratories that do not achieve the 95 percent goal, and to engage the Association of Public Health Laboratories (APHL) to assist in achieving this national goal. APHL has agreed to assume responsibility for monitoring its members. Because the current average is only at 75 percent accuracy, the goal of reaching and maintaining 90 percent on a national scale is ambitious because some organisms will be very difficult to identify. While the goal of the LRN is to achieve a 100 percent accuracy rate, it is reasonable to assume that successful participation on a national scale would entail a success rate of 90 percent or greater accuracy.

HIV/AIDS, STD, AND TB PREVENTION

EFFICIENCY MEASURE (DOMESTIC HIV/AIDS)	TARGETS	ACTUAL PERFORMANCE	REF.
1. Decrease the amount of time in the review and oversight process for directly-funded CBOs, as reflected in the number of CDC programs for CBOs.	FY 2006: 3 program announcements FY 2005: 3 current announcements	FY 2006: 12/2006 FY 2005: 12/2005 FY 2004: 3 program announcements FY 2003: 9 current program announcements	HHS-8

Efficiency Measure 1:

In FY 2004, CDC consolidated six program announcements for Community Based Organizations (CBOs) into one program announcement. The consolidation decreased the administrative work at CDC required to develop, publish, compete, review and award six different program announcements. This consolidation also provided CDC with the opportunity to improve oversight of grantees by reducing the number of different grant requirements which project officers are expected to know. Finally, the new program announcement included a set of core performance indicators to monitor and evaluate grantee performance.

The review process used to evaluate applications involves convening special emphasis panels, obtaining subject matter experts, conducting pre-decisional site visits and budget negotiations, and developing technical reports for each program announcement. With a consolidation of six program announcements to one announcement, CDC was able to streamline the review and oversight process thereby decreasing staff time and cost for all of these functions.

OVERARCHING HIV/AIDS PREVENTION

Historically, new AIDS cases (AIDS incidence) were the basis for assessing needs for prevention and treatment programs. However, potent new antiretroviral therapies are delaying or preventing the development of AIDS in many HIV-infected persons, and AIDS data are no longer sufficient to describe the epidemic. Data on HIV are now needed to monitor the effect of the epidemic. CDC is working with states to implement and improve HIV reporting and is studying methods to estimate HIV incidence nationally.

GOAL 1: BY 2010, REDUCE BY 25% THE NUMBER OF NEW HIV INFECTIONS IN THE U. S., AS MEASURED BY A REDUCTION IN THE NUMBER OF HIV INFECTIONS DIAGNOSED EACH YEAR AMONG PEOPLE UNDER 25 YEARS OF AGE, FROM 2,100 IN 2000 TO APPROXIMATELY 1,600 IN 2010.			
Performance Measure	Targets	Actual Performance	Ref
1. Reduce the number of HIV infection cases diagnosed each year among people under 25 years of age. [O]	FY 2006*: Overall: 2,420 reported cases in 30 areas FY 2005: Overall: 1,800 reported cases in 25 areas FY 2004: Overall: 1,900 reported cases in 25 areas	FY 2006: 8/2007 FY 2005: 8/2006 FY 2004: 8/2005 FY 2003: 2,331** in 25 areas FY 2002: 2,926** in 25 areas	HHS-1, PART, PAR

GOAL 1: BY 2010, REDUCE BY 25% THE NUMBER OF NEW HIV INFECTIONS IN THE U. S., AS MEASURED BY A REDUCTION IN THE NUMBER OF HIV INFECTIONS DIAGNOSED EACH YEAR AMONG PEOPLE UNDER 25 YEARS OF AGE, FROM 2,100 IN 2000 TO APPROXIMATELY 1,600 IN 2010.

Performance Measure	Targets	Actual Performance	Ref
2. Decrease the number of perinatally acquired AIDS cases, from the 1998 base of 235 cases. [O]	FY 2006: <100 cases FY 2005: <100 cases FY 2004: <100 cases FY 2003: <139 cases FY 2002: 141 cases	FY 2006: 8/2007 FY 2005: 8/2006 FY 2004: 8/2005 FY 2003: 58 (Exceeded) FY 2002: 90 (Exceeded)	HHS-1, HP-13.17, PAR

* FY 2006 targets for measures using HIV data are set based on data from 30 areas.

** All data have been modified to update annual "actual performance" numbers based on the most recent HIV and AIDS Surveillance data. Therefore, some values have changed for prior years.

Goal 1, Performance Measure 1:

The number of HIV infection cases among persons under 25 years of age diagnosed each year is the best data available to monitor new HIV infections. HIV infections occurring in this group are likely to have been acquired recently and thus are a relatively good proxy measure of HIV incidence. In addition, these data enable CDC to look at yearly trends in reported cases by risk, demographic, and geographic variables. They are from a national surveillance system that collects demographic, clinical, and behavioral information on all AIDS cases diagnosed in the U.S. as well as HIV cases diagnosed in states with HIV reporting requirements. FY 2004 and 2005 targets were set when only 25 states had stable, confidential name-based HIV reporting. Recent outbreaks of syphilis among men who have sex with men (MSM) have raised concerns that the incidence of HIV may be rising rather than decreasing. CDC is working to halt potential increases in incidence. The FY 2006 target has been raised to reflect the addition of data from five additional areas.

Goal 1, Performance Measure 2:

Surveillance data published through 2003 show sharply declining trends in perinatal AIDS cases since the mid 1990s. This decline was strongly associated with increasing zidovudine use in pregnant women who were aware of their HIV status. More recently, improved treatment has also likely delayed onset of AIDS for HIV-infected children. With efforts to maximally reduce perinatal HIV transmission and increase treatment for those infected, cases are likely to remain low.

DOMESTIC HIV/AIDS PREVENTION

GOAL 2: DECREASE THE NUMBER OF PERSONS AT HIGH RISK FOR ACQUIRING OR TRANSMITTING HIV INFECTION.

Performance Measure	Targets	Actual Performance	Ref
1. Among HIV-infected persons 18 years of age and over, reduce the proportion that had high-risk sex with a negative partner or partner of unknown status. [O]	FY 2006: <11% FY 2005: <10%	FY 2006: 8/2007 FY 2005: 8/2006 FY 2003: 13.2% FY 2002: 13.9% (Median) FY 2001: 12.3% (Median)	HHS-1

Goal 2, Performance Measure 1:

Because every new HIV infection is the result of transmission from an infected person, encouraging infected persons to adopt safe behaviors is one of the highest priorities of HIV prevention. Helping those who are infected to adopt safer behaviors is a key strategy of CDC's new HIV initiative, Advancing HIV Prevention (AHP). In 2004, CDC asked its state grantees to prioritize interventions with those who are HIV positive, and included prevention with positives as a key component of its new directly-funded CBO program. Targets and actual performance estimates represent the median figure from 16 participating areas.

**GOAL 3: BY 2010, INCREASE BY 13% THE PROPORTION OF HIV-INFECTED PEOPLE WHO KNOW THEY ARE INFECTED, AS MEASURED BY THE PROPORTION DIAGNOSED BEFORE PROGRESSION TO AIDS
(BASELINE: 76% IN 2000; TARGET FOR 2010: 85%)**

Performance Measure	Targets	Actual Performance	Ref
1. Among persons with HIV infection, increase the proportion diagnosed before progression to AIDS. [O]	FY 2006: 79% FY 2005: 80% FY 2004: 80%	FY 2006: 8/2007 FY 2005: 8/2006 FY 2004: 8/2005 FY 2003: 77%* FY 2002: 77%* Data are from 30 areas with stable HIV reporting systems	HHS-1, HP-13.15, PART
2. Among persons with HIV infection attributed to heterosexual behavior, increase the proportion diagnosed before progression to AIDS. [O]	FY 2003: 83% FY 2002: 82% FY 2001: 82%	FY 2003: 80% (Unmet) FY 2002: 81% (Unmet) FY 2001: 82% (Met) Data are from 30 areas with stable HIV reporting systems	HHS-1, HP-13.15
3. Among persons with HIV infection attributed to injecting drug use, increase the proportion diagnosed before progression to AIDS. [O]	FY 2003: 76% FY 2002: 76%	FY 2003: 72%* (Unmet) FY 2002: 74%* (Unmet) Data are from 30 areas with stable HIV reporting systems	HHS-1, HP-13.15
4. Among persons with HIV infection attributed to male-to-male sexual contact, increase the proportion diagnosed before progression to AIDS. [O]	FY 2003: 75% FY 2002: 74%	FY 2003: 77% (Exceeded) FY 2002: 76% (Exceeded) Data are from 30 areas with stable HIV reporting systems	HHS-1, HP-13.15
5. Increase the percentage of HIV-positive tests with post-test counseling sessions reported from CDC funded test sites. [O]	FY 2006: 75% FY 2005: 80% FY 2004: 80% FY 2003: 75% FY 2002: 75%	FY 2006: 2/2008 FY 2005: 2/2007 FY 2004: 2/2006 FY 2003: 2/2005 FY 2002: 71% (Unmet)	HHS-1

* All data have been modified to update annual "actual performance" numbers based on the most recent HIV and AIDS Surveillance data. Therefore, some values have changed from prior year.

Goal 3:

As deaths due to AIDS have decreased and the rate of new infections has remained stable, the number of persons living with HIV/AIDS has increased. If incidence does not decrease, the number of persons living with HIV and AIDS is expected to continue to increase slightly each year. Yet, of the estimated 850,000 to 950,000 persons infected with HIV in the U.S., up to one-fourth are unaware of their infection. Reducing the incidence of both new infections and HIV associated morbidity and mortality will require earlier testing and improved access to prevention and care services for persons with HIV. Research shows that persons who are aware of their infection are more likely to adopt behaviors to protect themselves and their partners. Thus, promoting knowledge of serostatus among those who are infected is essential in preventing new infections.

Goal 3, Performance Measures 1 – 4:

Measures 1 through 4 are indicators of the percentage of persons who learn of their infection before the latest stages of the disease, and before the development of an AIDS-defining condition. Compared with early testers, late testers are more likely to be young, to be Black or Hispanic, and to receive HIV testing because of illness. Early testers are more likely to seek testing because of self-perceived risk. The percentage of persons diagnosed with HIV and AIDS simultaneously should decrease over time if a greater proportion of HIV-infected persons find out their HIV status earlier. Activities related to these measures include efforts to increase knowledge of HIV status through voluntary counseling and testing, and to link HIV-positive persons with prevention, care, and treatment services.

Note: Measure 1 is a new measure intended to replace measures 2 through 4 under Goal 3. Measures 2 through 4 address the same issue, but are targeted to different risk groups and will be retired after data are reported for FY 2003.

Goal 3, Performance Measure 5:

The HIV Counseling and Testing System (CTS), initiated in 1990, is the principal source of information on the use of publicly funded HIV counseling, testing, and referral services in the U.S. Client demographic, behavioral, and HIV test results are reported to CTS about each reported HIV counseling, testing, and referral episode in a CDC-funded site. Each year, approximately two million HIV tests are reported from over 11,000 sites, each with varying test return rates. In 2002, there was a reported increase from 69.3 percent in 2000 to 71 percent in the percentage of HIV-positive test results from CDC-funded sites with post test counseling reported. CDC is working with all grantees to continue improving the return rates for HIV-positive test results and is evaluating grantees' reporting systems. Information obtained from the evaluation will be used to develop a comprehensive plan to ensure that all people who are tested and found to be HIV-positive at a CDC-funded site learn of their infection. Recent conditional approval by FDA of a rapid HIV-1 test will allow return of preliminary HIV test results "while you wait." These results still require confirmatory testing, with results shared at post-test counseling sessions. In FY 2002, two jurisdictions reported incomplete data and were not included in the overall calculation.

GOAL 4: BY 2010, INCREASE TO AT LEAST 80% THE PROPORTION OF HIV-INFECTED PEOPLE WHO ARE LINKED TO APPROPRIATE PREVENTION, CARE, AND TREATMENT SERVICES, AS MEASURED BY THOSE WHO REPORT HAVING RECEIVED SOME FORM OF MEDICAL CARE WITHIN 3 MONTHS OF THEIR HIV DIAGNOSIS (2001 BASELINE: 79%).			
Performance Measure	Targets	Actual Performance	Ref
1. Increase the proportion of HIV-infected people who received some form of medical care within 3 months of HIV diagnosis. [O] (Data are from interviews taken from a sample of persons in 16 areas.)	FY 2006: 80% FY 2005: 80% FY 2004: 80%	FY 2006: 8/2007 FY 2005: 8/2006 FY 2004: 8/2005 FY 2003: 80.4% FY 2002: 80.3%	HHS-1, PART
2. Refine methods for measuring long-term survival.	FY 2003: Expand new methods to include understanding of factors associated with long-term survival; publish final methods and instruments for collection of data on factors associated with long-term survival FY 2002: Develop new methods based on findings	FY 2003: Study closed out (Met) FY 2002: Study closed out (Met)	HHS-4

Goal 4, Performance Measure 1:

This measure reflects linkage to care after initial diagnosis. A physician should evaluate most HIV-infected persons soon after receiving the initial positive results. However, many persons are not evaluated because of fear or lack of access to medical care. The data for this measure are collected through interviews with HIV-infected persons in 16 areas.

Goal 4, Performance Measure 2:

Midway through the 1990s, effective therapies became available for HIV-infected persons. The effect of these treatments on AIDS incidence and deaths were detected at the population level through surveillance as early as 1996. As the number of deaths have decreased and the rate of new infection remained stable, AIDS prevalence has steadily increased each year. CDC has two longitudinal studies to determine long-term survival of patients in medical care. Analyses of the studies indicated the need to develop a more representative cross-sectional survey instrument. This measure will be retired after data are reported for FY 2003.

GOAL 5: STRENGTHEN THE CAPACITY NATIONWIDE TO MONITOR THE EPIDEMIC; DEVELOP AND IMPLEMENT EFFECTIVE HIV PREVENTION INTERVENTIONS; AND EVALUATE PREVENTION PROGRAMS.			
Performance Measure	Targets	Actual Performance	Ref
1. Increase the number of states and the District of Columbia that conduct HIV case reporting in adults and adolescents that meet CDC guidelines.	FY 2006: 50 states and D.C. FY 2005: 50 states and D.C. FY 2004: 50 states and D.C. FY 2003: 50 states	FY 2006: 10/2006 FY 2005: 10/2005 FY 2004: 50 states and DC; 38 use confidential, name-based reporting (Met) FY 2003: 49 states and D.C.; 34 use confidential, name-based reporting (Unmet)	HHS-1
2. Measure HIV incidence and prevalence in high-risk populations.	FY 2003: 30 sites FY 2002: 21 sites	FY 2003: 29 (Unmet) FY 2002: 21 (Met)	HHS-1

Goal 5, Performance Measure 1:

Currently, all states have implemented some form of HIV reporting. HIV reporting in the U.S. is currently conducted using one of three methods: 1) name; 2) code; and 3) name to code. A total of 36 states, the U.S., Virgin Islands, Guam, and Puerto Rico have confidential name-based reporting. A total of 14 states and the District of Columbia (15 areas) have adopted systems that use coded identifiers. CDC does not combine HIV data from areas using coded patient identifiers for HIV surveillance with data from other states when reporting HIV/AIDS cases nationally.

Goal 5, Performance Measure 2:

Testing technology can now distinguish recent or "incident" HIV infections from "remote" infections among those who test positive for HIV. In FY 2000 and FY 2001, CDC began funding prospective studies in 21 sites to measure HIV incidence and prevalence in high-risk populations, and in certain healthcare settings and geographical areas, to analyze and disseminate data from surveys to help evaluate the impact of HIV prevention efforts. The incidence studies used the new testing technology to measure HIV incidence. The data are used to guide local HIV prevention and care efforts. Only 29 sites were funded for FY 2003. New HIV incidence studies were piloted in FY 2002 and in FY 2003 studies were implemented in 24 sites. In FY 2004 studies were implemented in 10 additional sites for a total of 34 sites currently conducting incidence studies. Data from these incidence studies will be available in 2005. This measure will be retired after data are reported for FY 2003.

SEXUALLY TRANSMITTED DISEASES

CDC supports STD prevention and control by: 1) monitoring disease trends using national and local data to focus and assess current prevention activities; 2) conducting behavioral, clinical, and health services research and program evaluation to provide a scientific base for improving program efforts; 3) providing education and training through guideline development, 10 regional STD/HIV Prevention Training Centers, and programs to ensure that health care professionals are prepared to provide optimal STD treatment, care, and prevention services; 4) building national partnerships for STD prevention to educate health professionals, the public, and policymakers about the importance of STD prevention and the impact of STDs on the health of Americans, particularly women and infants, adolescents, and minority populations; and 5) providing financial, direct personnel, and technical assistance to state and local health departments to deliver clinical and prevention services.

Two foci are syphilis elimination and infertility prevention. In addition, CDC supports sentinel surveillance, formative communications research, and provider surveys to address HPV. High risk types of HPV are closely linked with the development of cervical cancer among women who do not receive regular PAP tests.

GOAL 6: REDUCE STD RATES BY PROVIDING CHLAMYDIA AND GONORRHEA SCREENING, TREATMENT, AND PARTNER TREATMENT TO 50% OF WOMEN IN PUBLICLY FUNDED FAMILY PLANNING AND STD CLINICS NATIONALLY.			
Performance Measure	Targets	Actual Performance	Ref
1. Reduce the prevalence of chlamydia among high-risk women under age 25. [O]	FY 2003: <10% FY 2002: <10%	FY 2003: 9.9% (Met) FY 2002: 10.1% (Unmet)	HHS-1

GOAL 6: REDUCE STD RATES BY PROVIDING CHLAMYDIA AND GONORRHEA SCREENING, TREATMENT, AND PARTNER TREATMENT TO 50% OF WOMEN IN PUBLICLY FUNDED FAMILY PLANNING AND STD CLINICS NATIONALLY.

Performance Measure	Targets	Actual Performance	Ref
2. Reduce the prevalence of chlamydia among women under age 25, in publicly funded family planning clinics. [O]	FY 2005: <5% median FY 2004: <5% median FY 2003: <5% median FY 2002: <5% median	FY 2005: 10/2006 FY 2004: 10/2005 FY 2003: 5.9% (Unmet) FY 2002: 5.6% (Unmet)	HHS-1, HP-25.1a
3. Reduce the incidence of gonorrhea in women aged 15 to 44. [O]	FY 2005: <250/100,000 women FY 2004: <250/100,000 women FY 2003: <250/100,000 women FY 2002: <250/100,000 women	FY 2005: 10/2006 FY 2004: 10/2005 FY 2003: 268/100,000 (Unmet) FY 2002: 279/100,000 (Unmet)	HHS-1, HP-25.2
4. Reduce the incidence of PID, as measured by a reduction in hospitalizations for PID, in women aged 15 to 44. [O]	FY 2003: <125/100,000 women FY 2002: <125/100,000 women	FY 2003: 12/2005 FY 2002: 142/100,000 (Unmet)	HHS-1
5. Reduce the number of initial visits to physicians for PID in women aged 15 to 44. [O]	FY 2004: <225,000 visits FY 2003: <225,000 visits FY 2002: <225,000 visits	FY 2004: 12/2005 FY 2003: 123,000 (Exceeded) FY 2002: 197,000 (Exceeded)	HHS-1, HP-25.6

Goal 6, Performance Measure 1:

Data on the prevalence of chlamydial infection in defined populations have been useful to monitor disease burden and guide screening programs. For example, CDC monitors trends in prevalence among women enrolled in the U.S. Department of Labor National Job Training Program for economically disadvantaged women aged 16 to 24 who entered the National Job Training Program in 28 states and Puerto Rico. Increased efforts to promote screening by medical practitioners are needed to achieve reductions in chlamydia in this and other populations. The source for this data is the U.S. Department of Labor; U.S. Job Corps. This measure will be retired after data are reported for FY 2003.

Goal 6, Performance Measure 2:

The median chlamydia test positivity among 15-24 year-old women who were screened during visits to selected family planning clinics in all states and outlying areas was 5.9 percent (range: 3.0 percent to 14.2 percent). However, in nearly all states, chlamydia positivity was greater than the Healthy People 2010 objective of three percent. The source for this data is the Infertility Prevention Program (IPP), CDC. Continued expansion of screening programs to populations with higher prevalence of disease and use of more sensitive tests have contributed to the increase in overall median positivity. This measure will be revised beginning in FY 2006 (see below).

Goal 6, Performance Measure 3:

The U.S. experienced a 73.8 percent decline in the reported rate of gonorrhea from 1975 to 1997. After a small increase in 1998, the gonorrhea rate has decreased slightly since 1998.

Among women aged 15 to 44, the 2003 rate was 268 per 100,000, which is above the target rate of 250. Although increased screening (usually associated with simultaneous testing for chlamydial infection), use of more sensitive diagnostic tests, and improved reporting may account for a portion of the recent increase, true increases in disease in some populations and geographic areas also appear to have occurred. The source for this data is the STD Morbidity Surveillance System, CDC. This measure will be retired after data are reported for FY 2005.

Goal 6, Performance Measure 4:

Hospitalizations for Pelvic Inflammatory Disease have decreased throughout the 1980s and early 1990s, but have remained relatively constant between 1995 and 2001. These trends may reflect changes in the etiology of PID (with increasing proportions of more asymptomatic chlamydial infection) as well as changes in the clinical diagnosis and management of PID rather than true trends in disease. A greater proportion of women diagnosed with PID in the 1990s have been treated in outpatient rather than inpatient settings when compared to women diagnosed with PID in the 1980s. In general, incidence is declining, but because of variations in the sampling frame from year to year, annual fluctuations are likely. Because of this variability in sampling frame, CDC focuses on trends in disease incidence rather than a single year data point. This measure will be retired after data are reported for FY 2003.

Goal 6, Performance Measure 5:

The reported number of initial visits to physicians' offices for PID through the National Disease and Therapeutic Index has declined from 1993 through 2003. CDC conducts screening for chlamydia and gonorrhea to prevent PID resulting from untreated infection. The source for this data is the National Disease and Therapeutic Index, IMS America, Ltd. This measure will be retired after data are reported for FY 2004. Beginning in FY 2006, this measure will be moved to goal nine to reflect the importance of reducing this adverse health outcome.

GOAL 7: REDUCE THE INCIDENCE OF P&S SYPHILIS.			
Performance Measure	Targets	Actual Performance	Ref
1. Increase the percentage of U.S. counties with an incidence of P&S syphilis in the general population of 4/100,000. [O]	FY 2005: >95% of counties FY 2004: >95% of counties FY 2003: >95% of counties FY 2002: >92% of counties	FY 2005: 10/2006 FY 2004: 10/2005 FY 2003: 95% (Met) FY 2002: 94% (Exceeded)	HHS-1, HP-25.3
2. Reduce the racial disparity (reported ratio is black: white) [FY 03 and prior FYs, measure written as "increase the percentage reduction in the racial disparity]. [O]	FY 2005: 11:1 FY 2004: 13:1 FY 2003: 15% to 14:1 FY 2002: 15% to 17:1	FY 2005: 10/2006 FY 2004: 10/2005 FY 2003: 38% reduction to 5:1 (Exceeded) FY 2002: 50% reduction to 8:1 (Exceeded)	HHS-3, HP-25.3

Goal 7, Performance Measure 1:

The rate of primary and secondary (P&S) syphilis in the U.S. declined by 89.2 percent from 1990 through 2000. In 2003, 95 percent of U.S. counties had an incidence of P&S syphilis in the population equal or below four per 100,000. However, syphilis remains an important problem in the South and in some urban areas in other regions of the country. Recently, outbreaks of syphilis among MSM have been reported, possibly reflecting an increase in risky behavior in this population. The rate of P&S syphilis increased slightly in 2003 from 2.4 to 2.5 per 100,000; this increase was observed only in men as syphilis cases in women declined. The number of P&S syphilis cases reported to CDC increased to 7,177 in 2003 from 6,862 in 2002. In 2006, this measure will be replaced with two measures to reduce the incidence of primary and secondary syphilis among men and women. The source for this data is the STD Morbidity Surveillance System, CDC.

Goal 7, Performance Measure 2:

Syphilis remains one of the most glaring examples of racial disparities in health, with 2003 rates among African Americans five times those among white Americans, down from a 64-fold differential at the beginning of the last decade. While substantially reduced from previous years, this disparity (5:1) is still much higher than that for other health outcomes: including infant mortality (2.5:1), and deaths attributable to heart disease (1.5:1). Communities burdened by poverty, racism, unemployment, low rates of health insurance, and inadequate access to healthcare are often disproportionately affected by syphilis. CDC aims to continue reducing this racial disparity in 2004 and 2005. The source for this data is the STD Morbidity Surveillance System, CDC. This measure will be revised beginning in FY 2006 (see below).

GOAL 8: REDUCE THE INCIDENCE OF CONGENITAL SYPHILIS.			
Performance Measure	Targets	Actual Performance	Ref
1. Reduce the incidence of congenital syphilis per 100,000 births. [O]	FY 2005: <12 FY 2004: <12 FY 2003: <12 FY 2002: <12	FY 2005: 10/2006 FY 2004: 10/2005 FY 2003: 10.3 (Exceeded) FY 2002: 11.3 (Exceeded)	HHS-1, HP-25.9

Goal 8, Performance Measure 1:

The lack of syphilis serologic testing and treatment during pregnancy remains the major reason that congenital syphilis persists in the U.S. Each positive test in a child is considered a medical emergency with immediate health services follow-up. The absence of testing is often related to complete lack of, or late initiation of prenatal care. Between 2002 and 2003, the overall rate of congenital syphilis decreased in the U.S., from 11.3 to 10.3 cases per 100,000 live births.

The continuing decrease in the rate of congenital syphilis likely reflects the substantial reduction in the rate of P&S syphilis among women that has occurred in the last decade. During 1992 through 2002, the average yearly percentage decrease in the congenital syphilis rate was 19.2 percent. The average yearly percentage decrease in the rate of P&S syphilis reported among women for the years 1992 through 2002 was 21.2 percent. The source for this data is the STD Morbidity Surveillance System, CDC. This measure will be revised beginning in FY 2006 (see below).

Goals 9 and 10:

During the FY 2006 budget process, CDC's STD Prevention program underwent a PART review by the Office of Management and Budget. This process helped CDC redirect and refine its performance measures for STD prevention and control. Based on its PART review, CDC has revised its two goals for STD prevention. Beginning in FY 2006, CDC will track the following goals and measures (Goals nine and 10) and will no longer report on Goals six through eight.

GOAL 9: BY 2010, REDUCE THE INCIDENCE OF PELVIC INFLAMMATORY DISEASE (PID) BY 15% (AS MEASURED BY INITIAL VISITS TO PHYSICIANS BY WOMEN AGES 15-44).*			
Performance Measure	Targets	Actual Performance	Ref
1. Reduce the prevalence of chlamydia among high-risk women under age 25 by 15%. [O]	FY 2006: 9.3%	FY 2006: 10/2007 FY 2002: 10.1% (Baseline)	HHS-1, PART
2. Reduce the prevalence of chlamydia among women under age 25, in publicly funded family planning clinics by 15%. [O]	FY 2006: 5.3%	FY 2006: 10/2007 FY 2002: 5.6% (Baseline)	HHS-1, HP-25.1a
3. Reduce the incidence of gonorrhea in women aged 15 to 44 by 15%. [O]	FY 2006: 257/100,000	FY 2006: 10/2007 FY 2002: 279/100,000 (Baseline)	HHS-1, HP-25.2

Goal 9, Performance Measure 1:

Data on the prevalence of chlamydial infection in defined populations have been useful to monitor disease burden and guide screening programs. For example, CDC monitors trends in prevalence among women enrolled in the U.S. Department of Labor National Job Training Program for economically disadvantaged women aged 16 to 24 who entered the National Job Training Program in 28 states and Puerto Rico. Increased efforts to promote screening by medical practitioners are needed to achieve reductions in chlamydia in this and other populations. The source for this data is the U.S. Department of Labor; U.S. Job Corps.

Goal 9, Performance Measure 2:

Chlamydia remains widespread and is a significant threat to women's health. Because chlamydia is usually asymptomatic and is most common among young women, CDC recommends annual chlamydia screening for sexually active women under age 25. The source for this data is the Infertility Prevention Programs (IPP), CDC.

Goal 9, Performance Measure 3:

Chlamydia and gonorrhea are the most important preventable causes of infertility and potentially fatal tubal pregnancy. CDC conducts screening for chlamydia and gonorrhea to prevent PID from untreated infection. If not adequately treated, up to 40 percent of women infected with chlamydia or gonorrhea will develop infection (i.e., PID) in the uterus or fallopian tubes. PID can lead to infertility or ectopic pregnancy. These measures reflect the importance of reducing this adverse health outcome. The source for this data is the STD Morbidity Surveillance System; CDC.

GOAL 10: REDUCE THE INCIDENCE OF PRIMARY AND SECONDARY (P&S) SYPHILIS BY 12% AND CONGENITAL SYPHILIS BY 62%.*			
Performance Measure	Targets	Actual Performance	Ref
1a) Reduce the incidence of P&S syphilis in men per 100,000 population by 7%. [O]	FY 2006: Establish baseline **	FY 2006: 10/2007	HHS-1, PART

GOAL 10: REDUCE THE INCIDENCE OF PRIMARY AND SECONDARY (P&S) SYPHILIS BY 12% AND CONGENITAL SYPHILIS BY 62%.*			
Performance Measure	Targets	Actual Performance	Ref
1b) Reduce the incidence of P&S syphilis in women per 100,000 population by 65%. [O]	FY 2006: 0.58/100,000	FY 2006: 10/2007 FY 2002: 1.1/100,000 (Baseline)	HHS-1, PART
2. Reduce the incidence of congenital syphilis per 100,000 live births. [O]	FY 2006: 6.0/100,000	FY 2006: 10/2007 FY 2002: 11.3/100,000 (Baseline)	HHS-1, HP-25.2
3. Reduce the racial disparity of P&S syphilis by 63% (reported ratio is black:white). [O]	FY 2006: 3.6 to 1	FY 2006: 10/2007 FY 2002: 8.1 to 1 (Baseline)	HHS-3, HP-25.1a

* Beginning in FY 2006, these goals and measures will replace existing goals (Goals 6 – 8) and their measures. These changes are a result of the PART review process by OMB.

** In FY 2002, the incidence of P&S syphilis in men was 3.8 per 100,000 (initial FY 2002 baseline). However, because of an outbreak of syphilis among men who have sex with men that occurred after 2002, CDC will report a new baseline for FY 2006. The overall goal for 2010 is a decrease in incidence to 2.2 per 100,000 as compared to the FY 2006 baseline.

Goal 10:

Syphilis, a genital ulcerative disease, facilitates the transmission of HIV and may be important in contributing to HIV transmission in parts of the U.S. where rates of both infections are high.

Goal 10, Performance Measure 1a:

Although the rate of P&S syphilis in the U.S. declined by 89.7% during 1990-2000, the rate of P&S syphilis remained unchanged between 2000 and 2001, and increased in 2002 and 2003. Overall increases in rates during 2001-2003 were observed only among men. Recent outbreaks of syphilis occurring among MSM have been reported and have been characterized by high rates of HIV co-infection and high-risk sexual behavior. The source for this data is the STD Morbidity Surveillance System, CDC.

Goal 10, Performance Measure 1b:

Syphilis rates in women have declined with the implementation of the Syphilis Elimination Plan (from 4.0/100,000 in 1999 to 1.8/100,000 in 2003). CDC will continue to strive to decrease syphilis cases among women, both to protect the health of women and to prevent congenital syphilis. Untreated early syphilis during pregnancy results in perinatal death in up to 40% of cases, and, if acquired during the four years preceding pregnancy, may lead to infection of the fetus in over 70% of cases. The source for this data is the STD Morbidity Surveillance System, CDC.

Goal 10, Performance Measure 2:

When a woman has a syphilis infection during pregnancy, she may transmit the infection to the fetus in utero. This may result in fetal death or an infant born with physical and mental developmental disabilities. Most cases of congenital syphilis are easily preventable if women are screened for syphilis and treated early during prenatal care. The source for this data is the STD Morbidity Surveillance System, CDC.

Goal 10, Performance Measure 3:

Syphilis remains one of the most glaring examples of racial disparities in health, with 2003 rates among African Americans five times those among white Americans, down from a 64-fold differential at the beginning of the last decade. The racial disparity (5:1) is higher compared to many other health outcomes: including infant mortality (2.5:1), and deaths attributable to heart disease (1.5:1). Communities burdened by poverty, racism, unemployment, low rates of health insurance, and inadequate access to healthcare are often disproportionately affected by syphilis. The source for this data is the STD Morbidity Surveillance System, CDC.

TUBERCULOSIS

GOAL 11: PROGRESS TOWARDS TB ELIMINATION IN THE U. S. (DEFINED AS LESS THAN 1 CASE/1,000,000 POPULATION) BY ACHIEVING AN INTERIM TB RATE OF 1 CASE/100,000 POPULATION IN U.S.-BORN PERSONS AND 20 CASES/100,000 POPULATION IN FOREIGN-BORN PERSONS RESIDING IN THE U. S., AND 3 CASES/100,000 POPULATION OVERALL, BY 2010.			
Performance Measure	Targets	Actual Performance	Ref
1. Decrease the number of persons with TB among US-born persons, foreign-born persons, and overall (per 100,000 population).	FY 2006: US-born 1.9; Foreign born 21.2; Overall 3.9	FY 2006: 9/2007	HHS-1, HP-14.11, PART
2. Increase the percentage of TB patients who complete a course of curative TB treatment within 12 months of initiation of treatment (some patients require more than 12 months). [O]	FY 2006: 88% FY 2005: 88% FY 2004: 88% FY 2003: 88% FY 2002: 88%	FY 2006: 9/2009 FY 2005: 9/2008 FY 2004: 9/2007 FY 2003: 9/2006 FY 2002: 9/2005 FY 2001: 80.5% FY 2000: 80.2% FY 1999: 67.6% (Baseline)	HHS-1, HP-14.12
3. Increase the percentage of TB patients with initial positive cultures who also have drug susceptibility results. [O]	FY 2006: 95% FY 2005: 95% FY 2004: 95% FY 2003: 95% FY 2002: 95%	FY 2006: 9/2007 FY 2005: 9/2006 FY 2004: 9/2005 FY 2003: 90.1% (Unmet) FY 2002: 93% (Unmet) FY 1994: 74.7% (Baseline)	HHS-1
4. Increase the percentage of contacts of infectious (AFB smear-positive) cases that are placed on treatment for latent TB infection and complete a treatment regimen.	FY 2006: 59% FY 2005: 61% FY 2004: 61% FY 2003: 63% FY 2002: 63% FY 2001: 63% FY 2000: 70%	FY 2006: 9/2009 FY 2005: 9/2008 FY 2004: 9/2007 FY 2003: 9/2006 FY 2002: 9/2005 FY 2001: 9/2005 FY 2000: 56.7% (Unmet - preliminary result)	HHS-1, HP-14.13
5. For TB case reports sent to CDC from states, increase the percentage in which at least 90% of core data items are complete.	FY 2003: 95% FY 2002: 95%	FY 2003: 16 out of 22 core variables; 95% complete (Met) FY 2002: 16 out of 22 core variables; 95% complete (Met) Remaining variables Month/year arrived U.S. 86.3%; B skin test 93.1%; Initial drug susceptibility results 90.1%; Year of previous dx 90.1%; HIV status 47.4%; HIV status (25–44) 62.6%	HHS-5

Goal 11, Performance Measure 1:

Tuberculosis (TB) is a leading infectious killer of young adults worldwide, claiming the lives of more than two million people each year. Approximately one third of the world's population is latently infected with the bacterium that causes TB. An estimated 10 to 15 million U.S. citizens have latent TB infection, and about 10 percent of these

individuals will develop TB at some point in their lives. From 2002 to 2003, reported cases of TB in the U.S. declined 1.4 percent (from 15,075 to 14,871). Persons born outside the U.S. now account for half of all U.S. TB cases

Goal 11, Performance Measure 2:

Because completion of TB treatment is the most effective way to reduce the spread of TB and prevent its complications, this objective is the highest priority for CDC's TB program. Its achievement is vital to reduce TB cases and to eventually eliminate TB. Patients who do not complete therapy within 12 months are often difficult to treat and require numerous interventions. Significant new efforts must be made to achieve this objective. CDC supports outreach workers, hired from language, cultural, and ethnic groups with high TB incidence to help meet this objective.

Outreach workers help patients complete treatment through directly observed therapy incentives and other adherence strategies. CDC and the CDC-funded Model TB Centers also design and implement training and educational aids for health department and healthcare providers to improve the skills they need to help achieve this objective. By 2006, CDC anticipates that 88 percent of TB patients will complete therapy within 12 months. In 2001, 80.5 percent of patients were reported to have completed therapy within 12 months, an increase from 67.6 percent of patients in 1994.

Goal 11, Performance Measure 3:

Healthcare providers must know if a newly diagnosed infectious patient is infected with drug-sensitive or drug-resistant organisms so that appropriate drug therapy can be initiated. If this information is unknown, patients may receive inadequate treatment leading to the spread of drug-resistant organisms, additional morbidity, and mortality. The performance for this measure in 2003 was 90.1 percent, up from 74.7 percent in 1994. With continued progress, CDC expects that programs will achieve the 95 percent target in FY 2004-2006. Much of this progress is attributable to increased efforts of state and local health departments and hospital infection-control practitioners to address the resurgence of TB and to increase funding for health department laboratories to purchase state-of-the-art equipment needed to perform more accurate and rapid laboratory testing and confirmation for TB and multi-drug resistant TB.

Goal 11, Performance Measure 4:

Completion of treatment for latent TB infection among contacts of infectious TB cases is a cornerstone of U.S. efforts to reduce TB and eliminate the disease, second only to ensuring that those with active TB complete treatment with appropriate drugs. Contacts of smear-positive TB patients are at high risk of developing TB and therefore must be screened for infection. If infected, these contacts should be offered complete treatment for latent infection. The 1998 rate for this measure was 74 percent, up from 68.4 percent in 1993. Data from 1999 and later years is limited due to incomplete reporting from program areas. Performance reporting dates for FY 2002 – 2006 have been revised to accurately reflect the time lag in reporting data to CDC. Data from FY 2000 should be considered preliminary. CDC is re-analyzing the data for FY 2000 to take into account changes in the reporting system.

Through cooperative agreements with state and local health departments, CDC supports identifying and examining contacts of persons with active TB, as well as completing treatment for contacts who have latent TB infection. CDC is designing training for health department TB staff to improve their skills in this area. CDC is also working with the Health Resources and Services Administration (HRSA) and other federally funded programs serving groups at high risk for TB to facilitate testing and completion of treatment of latent TB infection.

Goal 11, Performance Measure 5:

To design and carry out community TB prevention and elimination efforts, public health officials and community leaders must identify the unique and ever-changing characteristics of TB in their communities. Significant progress is being made on this front. Since 1993, when the national TB case report was revised and expanded to include information on TB risk factors (such as HIV status), drug resistance, and treatment, the proportion of core variables that were at least 95 percent complete increased from seven of 18 to 16 of 22 in 2003. Progress can be attributed to CDC funding for TB surveillance activities and frequent telephone, electronic, and on-site communication between CDC and health department surveillance staff.

Two of the under-reported variables for this measure relate to information about the HIV status of TB patients. CDC is working with health department TB staff, state epidemiologists, HIV program staff, and others to resolve issues surrounding these items, many of which are related to HIV confidentiality issues. This measure will be retired after data are reported for FY 2003.

IMMUNIZATION

EFFICIENCY MEASURE	TARGETS	ACTUAL PERFORMANCE	REF.
1. Establish a target range for costs associated with assessing vaccination coverage levels and providing feedback (AFIX) in healthcare provider office and clinic settings. [E]	FY 2006: Provide feedback to grantees on methods to decrease AFIX costs.	FY 2006: 12/2007	HHS-8
	FY 2005: Identify methods to help decrease AFIX costs in grantees that are above the target range.	FY 2005: 12/2006	
	FY 2004: Establish baseline estimate for target range of costs.	FY 2004: 12/2005	

Efficiency Measure 1:

AFIX (Assessing immunization coverage levels in public and private provider settings, providing Feedback, encouraging Incentives for improved performance and eXchange of information) is a proven method of improving vaccination rates. CDC will establish the target range by reviewing grantee expenditure data in conjunction with data obtained from health services research and evaluation studies. CDC will encourage grantees to align their costs with the target range, so that additional AFIX visits can be conducted with the subsequent cost savings.

GOAL 1: REDUCE THE NUMBER OF INDIGENOUS CASES OF VACCINE-PREVENTABLE DISEASES.			
Performance Measure	Targets	Actual Performance	Ref
1. The number of indigenous cases of paralytic polio ¹ , rubella ¹ , measles ¹ , <i>Haemophilus influenzae</i> invasive disease (type b and unknown types) ² , diphtheria ³ , congenital rubella syndrome ⁴ , and tetanus ³ will remain at or be reduced to 0 by 2010. [O]	Measles	Measles	HHS-1, HP-14.1a, 14.1b, 14.1c, 14.1e, 14.1h, 14.1i, 14.1j, PART
	FY 2006: 50	FY 2006: 9/2007	
	FY 2005: 50	FY 2005: 9/2006	
	FY 2004: 50	FY 2004: 9/2005	
	FY 2003: 50	FY 2003: 32 (Exceeded)	
	FY 2002: 60	FY 2002: 26 (Exceeded)	
	Paralytic Polio	Paralytic Polio	
	FY 2006: 0	FY 2006: 9/2007	
	FY 2005: 0	FY 2005: 9/2006	
	FY 2004: 0	FY 2004: 9/2005	
	FY 2003: 0	FY 2003: 0 (Met)	
	FY 2002: 0	FY 2002: 0 (Met)	
	Rubella	Rubella	
	FY 2006: 15	FY 2006: 9/2007	
	FY 2005: 15	FY 2005: 9/2006	
	FY 2004: 15	FY 2004: 9/2005	
	FY 2003: 15	FY 2003: 7 (Exceeded)	
	FY 2002: 20	FY 2002: 10 (Exceeded)	
	<i>Haemophilus influenzae</i>	<i>Haemophilus influenzae</i>	
	FY 2006: 150	FY 2006: 9/2007	
FY 2005: 150	FY 2005: 9/2006		
FY 2004: 150	FY 2004: 9/2005		
FY 2003: 175	FY 2003: 259 b+unknown (Unmet)		
FY 2002: 175	FY 2002: 187 b+unknown (Unmet)		

GOAL 1: REDUCE THE NUMBER OF INDIGENOUS CASES OF VACCINE-PREVENTABLE DISEASES.			
Performance Measure	Targets	Actual Performance	Ref
	Diphtheria FY 2006: 5 FY 2005: 5 FY 2004: 5 FY 2003: 5 FY 2002: 5 Congenital rubella syndrome FY 2006: 5 FY 2005: 5 FY 2004: 5 FY 2003: 5 FY 2002: 5 Tetanus FY 2006: 25 FY 2005: 25 FY 2004: 25 FY 2003: 25 FY 2002: 25	Diphtheria FY 2006: 9/2007 FY 2005: 9/2006 FY 2004: 9/2005 FY 2003: 0 (Exceeded) FY 2002: 0 (Exceeded) Congenital rubella syndrome FY 2006: 9/2007 FY 2005: 9/2006 FY 2004: 9/2005 FY 2003: 1 (Exceeded) FY 2002: 1 (Exceeded) Tetanus FY 2006: 9/2007 FY 2005: 9/2006 FY 2004: 9/2005 FY 2003: 6 (Exceeded) FY 2002: 6 (Exceeded)	
2. Reduce the number of indigenous cases of mumps in persons of all ages from 666 (1998 baseline) to 0 by 2010. [O]	FY 2006: 200 FY 2005: 200 FY 2004: 200 FY 2003: 250 FY 2002: 250	FY 2006: 9/2007 FY 2005: 9/2006 FY 2004: 9/2005 FY 2003: 222 (Exceeded) FY 2002: 253 (Unmet)	HHS-1, HP-14.1f
3. Reduce the number of cases of pertussis among children under 7 years of age. [O]	FY 2006: 2,300 FY 2005: 2,300 FY 2004: 2,300 FY 2003: 2,500 FY 2002: 2,500	FY 2006: 9/2007 FY 2005: 9/2006 FY 2004: 9/2005 FY 2003: 3,719 (Unmet) FY 2002: 4,109 (Unmet)	HHS-1, HP-14.1g

¹ All ages.

² Children under five years of age.

³ Persons under 35 years of age.

⁴ Children under one year of age.

Data to measure the goal is obtained from various CDC sources, including the National Notifiable Disease Surveillance System (NNDSS); the National Congenital Rubella Syndrome Registry (NCRSR); the Active Bacterial Core Surveillance (ABCs), Emerging Infections Programs; and the National Health Interview Survey (NHIS).

Goal 1, Performance Measure 1:

Measles – Only 32 reported cases of indigenous measles occurred in the U.S. in 2003 among all age groups, surpassing the target of 50 cases.

Polio – In achievement of the FY 2003 target, no cases of paralytic polio due to indigenous transmission of wild polio virus have been reported in the U.S.

Rubella and Congenital Rubella Syndrome – The number of reported cases of rubella has dramatically declined from 57,600 when the vaccine was introduced in 1969. The FY 2003 target has been surpassed and progress was made over the past year. There was one confirmed case of a child born with Congenital Rubella Syndrome (CRS) in 2003; however, in spite of this one case, the program still exceeded the target. It is important to note some children born in 2003 may not be diagnosed with CRS until 2004 or later.

Haemophilus influenzae type B – Conjugate vaccines for the prevention of Haemophilus influenzae type b (Hib) are highly effective. Hib is no longer the leading cause of meningitis among children younger than five years old in the U.S. However, the number of possible cases reported increased from 120 cases in 1999 to 259 cases in 2003. The

GPRA target of 175 cases remains unmet. In accordance with the Healthy People 2010 goal, this measure was clarified to include both cases with type b and also unknown serotypes. In spite of the data clarification, disease targets remained the same. Because a portion of these cases were not serotyped, the number of unknown serotypes that are actually type b cannot be confirmed. Neither Healthy People 2010 targets or GPRA targets were reset to account for the type b confirmation difficulty. Therefore, it is possible that, although the number of cases increased in 2003, the number of type b cases (both serotyped and not) for which the vaccine is effective may have remained the same or decreased. There is some concern the increase of disease cases from 2002 – 2003 can be explained by disease reporting challenges that have arisen since surveillance was expanded.

Diphtheria – There were no cases of diphtheria in the U.S. in persons under 35 years of age in 2003, exceeding the target.

Tetanus – In 2003, there were six cases of tetanus in the U.S. among persons less than 35 years of age, which exceeded the target. Although substantial progress has been made to reduce and/or eliminate the incidence of tetanus, total eradication of this disease is unlikely to occur except under exceptional circumstances because the organism is found in the environment, and most cases are the result of wounds.

Goal 1, Performance Measure 2:

CDC exceeded its mumps disease reduction target in 2003. CDC's efforts to reduce the number of cases have been a tremendous success. The 1998 baseline of 666 cases has been reduced by two-thirds to 222 of confirmed and probably indigenous cases in 2003.

Goal 1, Performance Measure 3:

The 2003 GPRA target was to reduce the number of pertussis cases among children under seven years of age to 2,500. The actual number of cases in this age group was 3,719. This increase has been mainly among adolescents and adults and among infants less than three months of age. Children do not receive their first DTP vaccine until two months of age and are not fully protected until the fourth dose is received. This accounts for the cases in children less than three months of age. The increase likely has resulted both from an increase in circulating *Bordetella pertussis* and from increased surveillance activities, especially among older age groups. Prevention efforts are directed at maintaining high on-time vaccination rates and increasing knowledge of pertussis and the entire spectrum of clinical symptoms. These efforts will improve the management of pertussis cases and outbreaks.

GOAL 2: ENSURE THAT 2-YEAR-OLDS ARE APPROPRIATELY VACCINATED.			
Performance Measure	Targets	Actual Performance ⁴	Ref
1. Achieve or sustain immunization coverage of at least 90% in children 19- to 35-months of age for: -4 doses DTaP vaccine ¹ -3 doses Hib vaccine -1 dose MMR vaccine ² -3 doses hepatitis B vaccine -3 doses polio vaccine -1 dose varicella vaccine -4 doses pneumococcal conjugate vaccine (PCV7) ³	FY 2006: 90% coverage FY 2005: 90% coverage FY 2004: 90% coverage FY 2003: 90% coverage FY 2002: 90% coverage	FY 2006: 8/2007 FY 2005: 8/2006 FY 2004: 8/2005 FY 2003: DTaP 96%; Hib 94%; MMR 93%; Hepatitis B 92%; Polio 92%; Varicella 85% (Exceeded, with the exception of Varicella) FY 2002: DTaP 95%; Hib 93%; MMR 91 %; Hepatitis B 90%; Polio 90%; Varicella 81% (Exceeded, with the exception of Varicella)	HHS-1, HP-14.24a, PART, PAR

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

² Includes any measles containing vaccine.

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

⁴ Data are collected through the National Immunization Survey and reflect calendar years.

Goal 2, Performance Measure 1:

The Advisory Committee on Immunization Practices' (ACIP) Recommended Childhood and Adolescent Immunization Schedule recommends routine vaccination of children for these diseases. The target of 90 percent coverage was met in 2003 for most of the vaccines, except varicella which is the most recently introduced vaccine that has a measurable target. Varicella rates are rising with coverage at only 43 percent in 1998 reaching 85 percent in 2003. CDC is close to meeting the 90 percent varicella vaccines coverage goal which is especially impressive this soon after the introduction of this particular vaccine, since a child that has already been exposed to chickenpox does not receive the varicella vaccine. Preventing pneumococcal infections with PCV is becoming more important because of problems with treatment as a result of increasing antibiotic resistance. ACIP added PCV to the 2001 Recommended

Childhood Immunization Schedule. As this is a newly recommended vaccine, accountability for performance targets will begin in 2006.

GOAL 3: INCREASE THE PROPORTION OF ADULTS WHO ARE VACCINATED ANNUALLY AGAINST INFLUENZA (FLU) AND EVER VACCINATED AGAINST PNEUMOCOCCAL DISEASE.			
Performance Measure	Targets	Actual Performance	Ref
1. Increase the rate of flu and pneumococcal pneumonia vaccination in persons 65 years of age and older.	FY 2006: Flu 74%; pneumococcal 69% FY 2005: Flu 74%; pneumococcal 69% FY 2004: Flu 74%; pneumococcal 69% FY 2003: Flu 74%; pneumococcal 69% FY 2002: Flu 74%; pneumococcal 66%	FY 2006: 1/2008 FY 2005: 1/2007 FY 2004: 1/2006 FY 2003: Flu 66% (Unmet); pneumococcal 56% (Unmet) FY 2002: Flu 66% (Unmet); pneumococcal 55% (Unmet)	HHS-1, HP-14.29a, 14.29b
2. Achieve a vaccination rate of 60% among non-institutionalized high-risk adults aged 18 to 64 years for flu and pneumococcal pneumonia by 2010.	FY 2006: Flu 32%; pneumococcal 22% FY 2005: Flu 32%; pneumococcal 22% FY 2004: Flu 32%; pneumococcal 22% FY 2003: Flu 32%; pneumococcal 22% FY 2002: Flu 32%; pneumococcal 22%	FY 2006: 1/2008 FY 2005: 1/2007 FY 2004: 1/2006 FY 2003: Flu 34% (Met); pneumococcal 21% (Unmet) FY 2002: Flu 32% (Met); pneumococcal 19% (Unmet)	HHS-1, HP-14.29c, 14.29d

Data is collected through the National Health Interview Survey (NHIS) for non institutionalized populations and National Nursing Home Survey (NNHS), for institutionalized populations.

Goal 3, Performance Measure 1:

During the past decade, vaccination rates among older adults increased steadily as CDC implemented national strategies and promoted adult and adolescent immunization among healthcare providers and state and local governments. Influenza vaccine coverage rates among the elderly have continually increased, from 30 percent in 1989 to 66 percent in 2003. However, data suggest that influenza vaccination levels may have reached a plateau. Delays in distribution of influenza vaccine supplies during the 2000-2001 and 2003-2004 seasons and to a lesser degree in the 2001-2002 season posed additional challenges to increasing coverage levels. Because large gaps remain between existing coverage levels and some of the targets for subsequent years, CDC has decided to maintain a target of 74 percent for 2004, 2005 and 2006 for influenza vaccination.

An increasing proportion of older adults also reported receipt of pneumococcal vaccination, from 15 percent in 1989 to 56 percent in 2003. However the goal of 69 percent for 2003 was not met. Adult vaccination rates are slowly increasing and CDC has worked with the Centers for Medicaid and Medicare Services to raise the reimbursement rate for influenza and pneumococcal vaccines. The same applies to influenza vaccine, because large gaps remain between existing coverage levels and some of the targets for subsequent years, CDC has decided to maintain the same targets for 2004, 2005 and 2006 for pneumococcal vaccination in this age group.

Goal 3, Performance Measure 2:

The ACIP Recommended Adult Immunization Schedule recommends annual vaccination for influenza for adults at high risk of complications and pneumococcal vaccination once for those at high risk. There was significant progress toward meeting this goal in 2003. The 2003 target for influenza vaccination among this population was 32 percent and for pneumococcal vaccination, it was 22 percent. Actual performance was 34 percent for influenza and 21 percent for pneumococcal. Current levels of coverage among adults vary widely among age, risk, and racial and ethnic groups. High-risk adults aged 18 to 64 years may not have insurance coverage for influenza and pneumococcal vaccines. These vaccines are covered by Medicare, thus vaccinating greater numbers of older adults is feasible. Persons with high-risk conditions, such as heart disease and diabetes, remain at increased risk for these diseases.

GOAL 4: IMPROVE VACCINE SAFETY SURVEILLANCE.			
Performance Measure	Targets	Actual Performance	Ref
1. By 2010, improve capacity to conduct vaccine safety studies by increasing the number of persons in the linked databases to 13 million.	FY 2006: 10 million FY 2005: 10 million FY 2004: 10 million FY 2003: 10 million	FY 2006: 6/2007 FY 2005: 6/2006 FY 2004: 6/2005 FY 2003: 7.5 million (Unmet) FY 2002: 7.5 million (Baseline)	HHS-1, 2, 4, HP-14.31

Data collected from the National Notifiable Disease Surveillance System (NNDSS), as well as Vaccine Adverse Event Reporting System (VAERS), Vaccine Safety Datalink (VSD).

Goal 4, Performance Measure 1:

The Vaccine Safety Datalink (VSD) Project is a collaborative project involving CDC and several large health maintenance organizations (HMOs). The VSD was established primarily to assess vaccine safety issues in the U.S. through analyses of large-linked databases (LLBD) collected at the HMOs as part of their routine administration of health services. The databases contain the vaccination and medical records of millions of children and adults. VSD is an example of an LLDB that includes information on more than seven million people.

The performance target for this goal was not met in FY 2003 because increasing populations in LLDBs is contingent on cooperating entities, resources, and technologies. CDC's vaccine safety activities are not limited to this one project, thus the goal to improve vaccine safety surveillance is not entirely reflected in this one measure. An additional vaccine safety performance measure is being considered to better represent vaccine safety surveillance improvement outcomes.

HEALTH PROMOTION

CHRONIC DISEASE PREVENTION, HEALTH PROMOTION, AND GENOMICS

EFFICIENCY GOAL: DECREASE THE NUMBER OF HOURS SPENT EACH YEAR BY A PROGRAM TO COLLECT, AGGREGATE, ASSESS, AND ANALYZE PROGRAMMATIC DATA.			
Efficiency Measure	Targets	Actual Performance	Ref
1. Increase the number of Web-based management information systems resulting in savings of program staff time. [E]	FY 2006: 6 FY 2005: 6	FY 2006: 12/2006 FY 2005: 12/2005 FY 2004: 5 FY 2003: 4 (Baseline)	HHS-5, 8

Efficiency Measure 1:

As project officers focus less on program administration, they spend more time providing program consulting, which increases the level of efficiency of a project officer. As such, this measure defines the number of management information systems within divisions that project officers use to provide more efficient program consulting to recipients. Currently, staff and recipients use the following five information systems to collect programmatic information:

- Racial and Ethnic Approaches to Community Health Management Information System (REACH MIS).
- Office of Smoking and Health's (OSH) National Tobacco Control Program Chronicle.
- Breast and Cervical Cancer Minimum Data Elements (MDE).
- National Breast and Cervical Cancer Early Detection Program System for Technical Assistance Reporting (STAR).
- Division of Diabetes Translation Management Information System.

HEART DISEASE AND STROKE

GOAL 1: REDUCE DEATH AND DISABILITY DUE TO HEART DISEASE AND STROKE AND ELIMINATE DISPARITIES.			
Performance Measure	Targets	Actual Performance	Ref
1. Reduce the proportion of heart disease and stroke deaths that occur before transport to emergency services in states funded for basic implementation programs. [O]	FY 2006: Heart disease deaths 45%; Stroke deaths 43% FY 2005: Heart disease deaths 45%; Stroke deaths 43% FY 2004: Heart disease deaths 45%; Stroke deaths 43%	FY 2006: 9/2008 FY 2005: 9/2007 FY 2004: 9/2006 FY 2003: 9/2005 FY 2002: Heart disease deaths 48%; Stroke deaths 45% FY 2001: Heart disease deaths 47%; Stroke deaths 44% (Baseline)	HHS-1, 5, HP-12
2. Reduce the prevalence of uncontrolled high blood pressure (>140/90) among patients with hypertension, especially among populations at high risk, in states that collaborate with community health centers. [O]	FY 2006: 50% FY 2005: 50% FY 2004: 50%	FY 2006: 8/2006 FY 2005: 8/2005 FY 2004: 54% (Unmet) FY 2003: 60% FY 2002: 60% (Baseline)	HHS-1, 5, 6, HP-12.1

The heart disease measures for 2003 were inadvertently not included in the 2003 plan. Whereas 2003 dollars support the measures identified, 2003 targets were not provided.

Goal 1, Performance Measure 1:

Program activities are in place to achieve the performance measure of decreasing the proportion of heart disease and stroke pre-transport deaths. They include national and state-level health communication programs about symptom awareness and the need to call 911 for emergency transport. Intra and inter-state stroke networks, coalitions, and signs and symptoms campaigns have been developed.

In FY 2001, states began and will continue to assess public awareness for stroke and heart disease symptoms at the state level. Health communications tools to enhance signs and symptoms campaigns are being developed to help states reduce the proportion of heart attack and stroke deaths which occur before transport to emergency services. In FY 2001, the baseline proportion of deaths that occur before transport to emergency services was 47 percent for heart disease and 44 percent for stroke. In FY 2004 through 2006, CDC proposes to reduce that proportion to 45 percent for heart disease and 43 percent for stroke.

Goal 1, Performance Measure 2:

Program activities to achieve the performance measure of reducing the prevalence of uncontrolled high blood pressure among high-risk populations and patients with hypertension include collaborations between states and their Federally Qualified Community Health Centers, which provide healthcare to underserved, uninsured, and minority populations. To date, states have assisted health centers in conducting needs assessments, and providing hypertension training and educational assistance for providers related to national guidelines for hypertension care and prevention. Some states have also developed a stroke task force, which will further promote stroke prevention in the community health centers. For FY 2005 and FY 2006, CDC proposes to reduce the prevalence of uncontrolled high blood pressure (above 140/90) to 50 percent from a baseline of 60 percent in FY 2002.

Though the target was not met for FY 2004, there was a six percentage point decrease in the number of patients with uncontrolled high blood pressure. This improvement is indicative of the quality of care that is provided to high risk populations. Community health centers continue to enhance and align their systems and practices with evidence-based recommendations to reduce heart disease and stroke risk factors. As systems and practices are strengthened, it is CDC's expectation that the established targets will be met.

EARLY DETECTION OF BREAST AND CERVICAL CANCER

GOAL 2: INCREASE EARLY DETECTION OF BREAST AND CERVICAL CANCER BY BUILDING NATIONWIDE PROGRAMS IN BREAST AND CERVICAL CANCER PREVENTION, ESPECIALLY AMONG HIGH-RISK, UNDERSERVED WOMEN.			
Performance Measure	Targets	Actual Performance	Ref
1. Excluding invasive cervical cancers diagnosed on an initial screen in NBCCEDP, lower the age-adjusted rate of invasive cervical cancer in women aged 20 and older. [O]	FY 2006: <14/1000† FY 2005: <14/10,000† FY 2004: 15/100,000† FY 2003: 16/100,000† FY 2002: 22/100,000	FY 2006: 2/2008† FY 2005: 2/2007† FY 2004: 2/2006† FY 2003: 2/2005† FY 2002: 15/100,000 (Exceeded)	HHS-1, HP-3.4

† FY rate based on 3 years of data (see narrative text below).

Goal 2, Performance Measure 1:

CDC continues to meet the established target for an age-adjusted rate of invasive cervical cancer in women aged 20 and older to not more than 22 per 100,000 Pap tests provided. For FY 2002, the age-adjusted rate was 15 per 100,000, based on cumulative data from the beginning of the National Breast and Cervical Cancer Early Detection Program (NBCCEDP). Beginning in 2003, CDC moved to calculating this rate based on a rolling three-year timeframe rather than cumulative data (for instance, FY 2003 rate will reflect data for the time period 2001–2003). Using a three-year period ensures statistical stability in the rate.

GOAL 3: EXPAND COMMUNITY-BASED BREAST AND CERVICAL CANCER SCREENING AND DIAGNOSTIC SERVICES TO LOW INCOME, MEDICALLY UNDERSERVED WOMEN. FOR WOMEN DIAGNOSED WITH CANCER OR PRE-CANCER, ENSURE ACCESS TO TREATMENT SERVICES.			
Performance Measure	Targets	Actual Performance	Ref
<p>1. Increase the number of women screened. [O]</p> <p>Breast: mammogram or CBE Cervical: Pap Smear</p>	<p>FY 2006: Breast 401,000; Cervical 280,000</p> <p>FY 2005: Breast 401,000; Cervical 280,000</p> <p>FY 2004: Breast 381,682; Cervical 275,000</p>	<p>FY 2006: 2/2008</p> <p>FY 2005: 2/2007</p> <p>FY 2004: 2/2006</p> <p>FY 2003: 2/2005 FY 2002: Breast 394,146; Cervical 280,330 FY 2000: Breast: 229,000; Cervical: 247,192 (Baseline)</p>	<p>HHS-1, 3, 5, 6, HP-3.3, 3.4, 3.10</p>
<p>2. Increase the percentage of newly enrolled women who have not received a Pap test within the past 5 years. [O]</p>	<p>FY 2006: Cervical 25%</p> <p>FY 2005: Cervical 25%</p> <p>FY 2004: Cervical 22.5%</p>	<p>FY 2006: 2/2008</p> <p>FY 2005: 2/2007</p> <p>FY 2004: 2/2006</p> <p>FY 2003: 2/2005 FY 2002: 22.2% FY 2000: Cervical 21.7%(Baseline)</p>	<p>HHS-1, 3, 5, 6, HP-3.4, PART</p>
<p>3. Increase the percentage of women with abnormal results who receive a final diagnosis within 60 days of screening. [O]</p> <p>Breast: abnormal mammogram (suspicious of abnormality, highly suggestive of malignancy, or assessment incomplete) and/or abnormal CBE</p> <p>Cervical: abnormal Pap includes high grade SIL, squamous cancer, or abnormal glandular cells</p>	<p>FY 2006: Breast 87.5%; Cervical 64.5%</p> <p>FY 2005: Breast 87.5%; Cervical 64.5%</p> <p>FY 2004: Breast 86.5%; Cervical 64%</p>	<p>FY 2006: 2/2008</p> <p>FY 2005: 2/2007</p> <p>FY 2004: 2/2006</p> <p>FY 2003: 2/2005 FY 2002: Breast 82.8%; Cervical 63.0% FY 2000: Breast: 82.2%; Cervical: 61.2% (Baseline)</p>	<p>HHS-1, 3, 5, 6, HP-3.3, 3.4</p>

GOAL 3: EXPAND COMMUNITY-BASED BREAST AND CERVICAL CANCER SCREENING AND DIAGNOSTIC SERVICES TO LOW INCOME, MEDICALLY UNDERSERVED WOMEN. FOR WOMEN DIAGNOSED WITH CANCER OR PRE-CANCER, ENSURE ACCESS TO TREATMENT SERVICES.			
Performance Measure	Targets	Actual Performance	Ref
4. Increase the percentage of women with cancer who start treatment within 60 days of diagnosis. [O]	FY 2006: Breast 95.5%; Cervical 92.5% FY 2005: Breast 95.5%; Cervical 92.5% FY 2004: Breast 95%; Cervical 92%	FY 2006: 2/2008 FY 2005: 2/2007 FY 2004: 2/2006 FY 2003: 2/2005 FY 2002: Breast 92.9%; Cervical 88.6% FY 2000: Breast: 94%; Cervical: 88% (Baseline)	HHS-1, 3, 5, 6, HP-3.3, 3.4, PART
5. Cervical: Increase the percentage of women with precancerous lesions who start treatment within 90 days of diagnosis (includes CIN II, CIN III, and CIS). [O]	FY 2006: 94.5% FY 2005: 94.5% FY 2004: 94%	FY 2006: 2/2008 FY 2005: 2/2007 FY 2004: 2/2006 FY 2003: 2/2005 FY 2002: 90.3% FY 2000: 92.4% (Baseline)	HHS-1, 3, 5, 6, HP-3.4

Goal 3, Performance Measure 1:

CDC continues to increase the number of women screened through NBCCEDP. In FY 2002, CDC screened 394,146 women for breast cancer and 280,330 for cervical cancer. This reflects positive trends toward meeting CDC's FY 2004 (381,382 breast/275,000 cervical) and FY 2005/2006 (401,000 breast/280,000 cervical) targets.

Goal 3, Performance Measure 2:

CDC encourages programs to reach underserved women for screening, including women who are rarely or never screened for cervical cancer. CDC defines "never or rarely screened" women as those who have not had a Pap test within the past five years. Because the measure relates only to newly enrolled women, projects must enroll new, rarely, and never screened women each year to meet this target. Therefore, it is a challenging target to achieve over time because programs must continually tap into communities to identify those who are underserved.

Goal 3, Performance Measure 3:

In FY 2002, 82.8 percent of women with abnormal breast cancer screening results and 63.0 percent of women with abnormal cervical cancer screening results received a final diagnosis within 60 days. The FY 2002 figures represent a slight decrease in breast and increase in cervical timeliness of diagnostic follow-up over the FY 2000 baseline. The comparatively lower percentage for cervical cancer screening reflects challenges facing CDC's programs, including delays in Pap results reporting from laboratories, long waiting periods for appointments for diagnostic services, and difficulties in tracking "hard to reach" women.

Goal 3, Performance Measure 4:

In FY 2002, 92.9 percent of women diagnosed with breast cancer and 88.6 percent of women diagnosed with invasive cervical cancer initiated treatment within 60 days. These data have remained fairly consistent from the FY 2000 baseline.

Goal 3, Performance Measure 5:

For women diagnosed with precancerous cervical lesions, CDC has set a target of ensuring the start of treatment within 90 days to 94 percent in 2004 and 94.5 percent in FY 2005/2006. In 2000, the baseline was established at 92.4 percent.

DIABETES PREVENTION AND CONTROL

GOAL 4: INCREASE THE CAPACITY OF STATE DIABETES CONTROL PROGRAMS TO ADDRESS THE PREVENTION OF DIABETES AND ITS COMPLICATIONS AT THE COMMUNITY LEVEL.			
Performance Measure	Targets	Actual Performance	Ref
1. For states receiving CDC funding for DPCPs, increase the percentage of persons with diabetes who receive annual eye and foot exams. [O]	FY 2006: Eye 75%; Foot 70% FY 2005: Eye 75%; Foot 70% FY 2004: Eye 72%; Foot 62% FY 2003: Eye 72%; Foot 62% FY 2002: Eye 72%; Foot 62%	FY 2006: 10/2007 FY 2005: 10/2006 FY 2004: 10/2005 FY 2003: Eye 61.3% (Unmet); Foot 67.4% (Exceeded) FY 2002: Eye 64.2% (Unmet); Foot 66.6% (Exceeded)	HHS-1, 3, HP-5.13, 5.14, PART
2. For states receiving CDC funding for DPCPs, increase the percentage of persons with diabetes who receive at least two A1c measures per year. [O]	FY 2006: 72.5% FY 2005: 72.5% FY 2004: 72.5%	FY 2006: 10/2007 FY 2005: 10/2006 FY 2004: 10/2005 FY 2001: 63.3% FY 2000: 62.0% (Baseline)	HHS-1, 3, HP-5.12, PART
3. Increase the number of DPCPs that promote health system approaches among those who are at high risk for developing diabetes (New initiative).	FY 2006: 5 FY 2005: 5 FY 2004: 5	FY 2006: 10/2007 FY 2005: 10/2006 FY 2004: 10/2005 FY 2002: 0 (Baseline)	HHS-1, 6, HP-5.2

The measure stating, "In states with prediabetes programs, increase the proportion of people with prediabetes who engage in diabetes prevention practices (New initiative)" has been removed. This measure was developed in FY 2002 to address one of the Secretary's Initiatives. However, the initiative did not receive funding and is not going forward.

Goal 4, Performance Measure 1:

In FY 2003, CDC began analyzing the Behavioral Risk Factor Surveillance System (BRFSS) data for this measure. Rather than focusing solely on basic implementation DPCPs, CDC now analyzes data from all the basic implementation and capacity building DPCPs participating in the BRFSS. CDC is now also using adjusted data rather than crude data. These revisions have been made to clarify some of the performance measurement challenges revealed by the OMB PART review. CDC's Diabetes program was reviewed by PART during the FY 2004 budget cycle.

FY 2003 data indicate that eye exam rates declined slightly from 64.2 percent in FY 2002 to 61.3 percent in FY 2003. These data, while concerning, represent a single point in time. They are not representative of a multi-year average, and for that reason, CDC cannot determine if the change signals a declining trend or an anomaly.

CDC continues to work with the state DPCPs to influence the preventive care practices of health systems and to inform providers and persons with diabetes about the importance of receiving annual eye exams to discover and treat diabetes-related eye disease in the earliest stages.

Goal 4, Performance Measure 2:

Beginning in FY 2004, CDC introduced a new measure to capture funded states progress in increasing A1c testing rates to the recommended level. The A1c (A-one-C) test (short for hemoglobin A1c) measures blood glucose (sugar) control over the last three months. The suggested target for people with diabetes is seven percent; however, many people with diabetes have levels of nine percent or higher. Reducing blood glucose levels by just one percent among people with diabetes reduces their risk for microvascular complications (eye, kidney, and nerve disease) by 40

percent. This measure reflects the evolution of CDC's focus from process outputs to intermediate impact outcomes. In FY 2004 through 2006, CDC proposes to increase the percentage of persons with diabetes who receive at least two A1c measures per year in states receiving CDC funding to 72.5 percent, from the 2000 baseline of 62.0 percent.

Goal 4, Performance Measure 3:

CDC and its state-based DPCPs work with HRSA's BPHC and the Institute for Healthcare Improvement (IHI) to improve diabetes and pre-diabetes performance measures through improved care delivery systems, increased access, and decreased health disparities among medically underserved populations. The Diabetes Prevention Collaborative prototype involves five federally funded health centers and five DPCPs from across the country. The objectives of the Diabetes Prevention Collaborative are to identify the pre-diabetes population and those at highest risk for developing diabetes, and provide evidence-based lifestyle interventions to prevent and/or delay the progression to diabetes. Preliminary findings indicate that methods to identify the pre-diabetes population are effective. Lifestyle interventions are being tested for their effect on reaching population level goals of more than 7 percent weight loss and more than 150 minutes of exercise per week.

To date, 1,660 individuals who have met the risk criteria for pre-diabetes have received an oral glucose tolerance test; more than half of these individuals (852) were found to have either pre-diabetes or previously undiagnosed diabetes. The collaborative shows that better outcomes in diabetes care and prevention are possible when the focus is on empowering individuals, improving the health care delivery system, and linking to communities where people live.

TOBACCO USE PREVENTION

GOAL 5: REDUCE CIGARETTE SMOKING AMONG YOUTH.			
Performance Measure	Targets	Actual Performance*	Ref
1. Reduce the percentage of youth (grades 9–12) who smoke. [O]	FY 2007: 18.5% FY 2005: 20.2% FY 2003: 26.5% FY 2001: 34.2%†	FY 2007: 6/2008 FY 2005: 6/2006 FY 2003: 21.9% (Exceeded) FY 2001: 28.5% (Exceeded)	HHS-1, 7, HP-27.2

* Data are released biennially.

† YRBSS (Youth Risk Behavior Surveillance System) data released in June 2004 indicated achievement of the FY 2003 target, and CDC revised the teen smoking projections.

Goal 5, Performance Measure 1:

Between 1991 and 1997, the prevalence of current cigarette use among youth (grades 9 – 12) increased from 27.5 percent to 36.4 percent; however, since 1997, cigarette use among adolescents has declined substantially and in 2003 was at the lowest level since national surveys have been monitoring youth smoking. Factors that contributed to the decline include: 1) a 90 percent increase in the retail price of cigarettes from December 1997-May 2003, 2) increases in school-based efforts to prevent tobacco use, and 3) an increase in the proportion of young persons exposed through the mass media to smoking-prevention campaigns. All of these factors are components/and or recommendations of CDC's National Tobacco Control Program. Continued progress toward meeting the Healthy People 2010 objective of reducing smoking among high school youth to 16 percent or less will require sustained efforts for evidence-based public health interventions.

NUTRITION AND PHYSICAL ACTIVITY PROGRAMS TO PREVENT OBESITY AND OTHER CHRONIC DISEASES

GOAL 6: DECREASE LEVELS OF OBESITY, OR REDUCE THE RATE OF GROWTH OF OBESITY, IN COMMUNITIES THROUGH NUTRITION AND PHYSICAL ACTIVITY INTERVENTIONS.			
Performance Measure	Targets	Actual Performance	Ref
1. Increase the number of nutrition and physical activity interventions that are implemented and evaluated in funded states.	FY 2006: 20 interventions FY 2005: 20 interventions FY 2004: 12 interventions	FY 2006: 12/2007 FY 2005: 12/2006 FY 2004: 12/2005 FY 2002: 0 interventions (Baseline)	HHS-1, 5, HP-19, 22

Goal 6, Performance Measure 1:

Since the inception of the program in FY 1999, funded states have been developing statewide action plans and initiating and evaluating interventions. State partners include public health organizations, food producers and marketers, medical and education providers, parks and recreation, transportation, and urban planning agencies, local media, and communities. All states are developing, implementing and evaluating nutrition and physical activity health promotion interventions to address overweight and chronic disease in specific populations. Results will include a number of refined programs, ready for adoption by other states and communities. Funded states are also improving their capacity to address the physical activity, nutrition and obesity prevention goals in part by working across programs such as diabetes, cardiovascular disease, asthma, school health, the Supplemental Food Program for Women, Infants and Children, as well as other programs that can benefit from overweight prevention and control.

SCHOOL HEALTH PROGRAMS

GOAL 7: REDUCE THE PERCENTAGE OF HIV/AIDS-RELATED RISK BEHAVIORS AMONG SCHOOL-AGED YOUTH THROUGH DISSEMINATION OF HIV PREVENTION EDUCATION PROGRAMS.			
Performance Measure	Targets	Actual Performance*	Ref
1. Achieve and maintain the percentage of high school students who are taught about HIV/AIDS prevention in school at 90% or greater. [O]	FY 2007: 90% or more FY 2005: 90% or more FY 2003: 90% or more FY 2001: 90% or more	FY 2007: 6/2008 FY 2005: 6/2006 FY 2003: 87.9% (Unmet) FY 2001: 89% (Unmet)	HHS-1, 2, 5, 7, HP-25
2. Increase the proportion of adolescents (grades 9–12) who abstain from sexual intercourse or use condoms if currently sexually active. [O]	All adolescents FY 2007: 89% FY 2005: 89% FY 2003: 89% FY 2001: 89% African-American adolescents FY 2007: 87% FY 2005: 87% FY 2003: 87% FY 2001: 87% Hispanic adolescents FY 2007: 88% FY 2005: 88% FY 2003: 88% FY 2001: 88	All adolescents FY 2007: 6/2008 FY 2005: 6/2006 FY 2003: 87.5% (Unmet) FY 2001: 86% (Unmet) African-American adolescents FY 2007: 6/2008 FY 2005: 6/2006 FY 2003: 87% (Met) FY 2001: 85% (Unmet) Hispanic adolescents FY 2007: 6/2008 FY 2005: 6/2006 FY 2003: 84.4% (Unmet) FY 2001: 84% (Unmet)	HHS-1, 7, HP-25.11

* Data are released biennially.

Goal 7, Performance Measure 1:

Data from the 2003 national Youth Risk Behavior Survey (YRBS) demonstrate that 87.9 percent of high school students have been taught HIV/AIDS prevention in school (FY 2003 target was 90 percent or higher). The 2003 data indicate that this measure has decreased since 1997 (92 percent) and that the small fluctuations in 1999 (91 percent) and in 2001 (89 percent) are not significantly different from time to time when considering the confidence intervals associated with sample data. CDC will continue to analyze these data and evaluate the policies, programs, and strategies in place to continuously improve the effectiveness of school-based HIV/AIDS prevention education. This measure is highly relevant and important to prevention efforts. Data are released biennially.

Goal 7, Performance Measure 2:

Data from the 2003 national YRBS demonstrate that 87.5 percent of all adolescents (FY 2003 target was 89 percent), 87 percent of African-American adolescents (FY 2003 target was 87 percent), and 84.4 percent of Hispanic adolescents (FY 2003 target was 88 percent) abstained from sexual intercourse or used condoms if sexually active. The target has been met for African-American adolescents. Progress has been made from 1991 to 2001.

CDC will continue to review, analyze, and discuss the possible reasons for not reaching the FY 2003 targets for all adolescents and Hispanic adolescents, in consultation with CDC's funded states, cities, and national

nongovernmental organizations, and will make programmatic adjustments as needed to improve program effectiveness required to reach the stated targets. Data are released biennially.

RACIAL AND ETHNIC APPROACHES TO COMMUNITY HEALTH (REACH) 2010

GOAL 8: BY 2010, IMPROVE THE LIVES OF RACIAL AND ETHNIC POPULATIONS WHO SUFFER DISPROPORTIONATELY FROM THE BURDEN OF DISEASE AND DISABILITY, AND DEVELOP TOOLS AND STRATEGIES THAT WILL ENABLE THE NATION TO ELIMINATE THESE HEALTH DISPARITIES.			
Performance Measure	Targets	Actual Performance	Ref
1. Develop national strategies (recommendations) to eliminate gaps in the six health priority areas based on the interventions and disseminate findings from the REACH 2010 Projects.	FY 2006: Convene annual meeting of grantees to review and describe strategies developed to date. Disseminate promising strategies (recommendations) for the elimination of health disparities.	FY 2006: 10/2006 FY 2003: Grantee meetings held in December 2003, June and October 2004; Dissemination of strategies began in July 2004 (Baseline)	HHS-1, 3, HP-3.3, 3.4, 5, 12, 13, 14, 16.1
2. Collect qualitative and quantitative data in REACH 2010 communities to evaluate community capacity-building, intervention strategies, systems change, change among change agents, and change in risk/protective behaviors.	FY 2006: REACH 2010 Risk Factor Survey data (quantitative) on changes in risk/protective behaviors will be collected and disseminated in 100% of the communities with health priority areas in breast and cervical cancer, cardiovascular diseases, and diabetes, (excluding the REACH Elderly projects); 85% of REACH 2010 communities will collect and disseminate data (qualitative). FY 2005: REACH 2010 Risk Factor Survey data (quantitative) on changes in risk/protective behaviors will be collected and disseminated in 100% of the communities with health priority areas in breast and cervical cancer, cardiovascular diseases, and diabetes, (excluding the REACH Elderly projects); 85% of REACH 2010 communities will collect and disseminate data (qualitative). FY 2004: REACH 2010 Risk Factor Survey data (quantitative) on changes in risk/protective behaviors will be collected and disseminated in 100% of the communities with health priority areas in breast and cervical cancer, cardiovascular diseases, and diabetes, (excluding the REACH Elderly projects); 60% of REACH 2010 communities will collect and disseminate data (qualitative).	FY 2006: 0/2007 FY 2005: 10/2006 FY 2004: 10/2005	HHS-3, 4

Goal 8, Performance Measure 1:

CDC continues to work towards the development of national strategies (recommendations) for eliminating gaps in each of the six health priority areas based on the interventions and findings from the REACH 2010 Projects.

The dissemination of the most promising strategies and of lessons learned is critical to the overall effectiveness of this demonstration project. Preliminary measures have been taken to assess the dissemination strategies used by other programs at CDC. Partners that are critical in developing the dissemination plan include the funded communities, evaluation experts, external consultants, private partners, and other federal agencies. FY 2003 effective processes and strategies utilized by REACH 2010 Communities will be documented for replication at the federal level and with private partners such as the California Endowment. Partnerships established with the private sector and evaluation experts are critical components of this demonstration program.

Goal 8, Performance Measure 2:

The evaluation of REACH 2010 is of critical importance in determining the program's effectiveness in reducing health disparities. Working with its grantees and partners, CDC has developed an evaluation model that guides the collection of qualitative and quantitative data.

In FY 2004 and FY 2005, CDC will collect and review quantitative data to examine changes in risk/protective behaviors in communities with health priority areas in Breast and Cervical Cancer, Cardiovascular Disease, and Diabetes (excluding the Administration on Aging and American Indian/Alaska Native projects). Data will be collected through a behavioral surveillance instrument called the REACH 2010 Risk Factor Survey. The Survey contains a series of questions related to physical activity, nutrition, heart disease and stroke, diabetes, and breast and cervical cancer. The collection of these data will inform the REACH 2010 program of widespread risk and protective behavior changes in the REACH 2010 communities and will assist the communities and CDC in tailoring prevention/intervention activities to the specific characteristics of the community.

In addition, CDC will collect and disseminate qualitative data related to three stages of the REACH 2010 Evaluation Logic Model: (1) community capacity-building activities, (2) intervention strategies, and (3) systems change, and change among change agents. Information will be collected through an internet-based data warehousing application called the REACH Information Network (REACH IN). REACH grantees will use the system to document current resources, identify specific needs, and document efforts and outcomes. The system will allow funded communities and CDC to monitor indicator outcomes related to specific health priority areas.

BIRTH DEFECTS, DEVELOPMENTAL DISABILITIES, DISABILITY AND HEALTH

EFFICIENCY MEASURE	TARGETS	ACTUAL PERFORMANCE	REF.
1. Establish an ongoing data management center for developmental disabilities monitoring and research sites, resulting in savings of program staff time. [E]	FY 2005: Establish data center	FY 2005: 12/2006	HHS-8, HP-16.14
2. Increase the number of autism cases included in the data coordinating center, resulting in savings of program and staff time and expediting efforts to understand the prevalence and find the causes of autism. [E]	FY 2006: 250	FY 2006: 12/2007	HHS-8, HP-16.14

Efficiency Measure 1:

CDC supports 18 states to track autism and other developmental disabilities (including CDC's own model tracking program in Atlanta). These efforts are essential for CDC to fulfill its Congressional mandate to collect, analyze, and disseminate autism data. The establishment of an ongoing data management center for these sites will result in significant time savings. This type of data coordination requires a core of expertise, which is most efficiently used by housing it in one location rather than using CDC staff time and having each site hire staff for this function. The first step in accomplishing these savings is to establish the baseline for this measure by creating the data center (FY 2005). This measure will be retired after data are reported for FY 2005.

Efficiency Measure 2:

Following the establishment of a data management center for developmental disabilities, CDC will be able to track progress in this area by focusing on increasing the number of autism cases included in the coordinating center, thus saving program and staff time and expediting efforts to understand the prevalence and causes of autism.

GOAL 1: PREVENT BIRTH DEFECTS AND DEVELOPMENTAL DISABILITIES.			
Performance Measure	Targets	Actual Performance	Ref
1. Decrease the percentage of women who report any alcohol consumption during pregnancy. [O]	FY 2006: 8.0% FY 2005: 8.5% FY 2004: 10.0% FY 2003: 11.5%	FY 2006: 12/2008 FY 2005: 12/2007 FY 2004: 12/2006 FY 2003: 12/2005 FY 2002: 10.1% (Baseline)	HHS-1, HP-16.17
2. Reduce by 1% per year the number of children born with spina bifida and anencephaly through promotion of folic acid consumption by women of reproductive age. [O]	FY 2006: 4% reduction FY 2005: 3% reduction FY 2004: 2% reduction FY 2003: 1% reduction	FY 2006: 12/2009 FY 2005: 12/2008 FY 2004: 12/2007 FY 2003: 12/2006 FY 2002: 12/2005	HHS-5, HP-16.15-16
3. Increase the number of U.S. births covered by birth defects monitoring programs, which use these data to plan services for children and evaluate prevention strategies.	FY 2006: 2,900,000 FY 2005: 2,800,000 FY 2004: 2,700,000 FY 2003: 2,600,000	FY 2006: 10/2006 FY 2005: 10/2005 FY 2004: 2,644,925 (Unmet) FY 2003: 2,609,477 (Exceeded)	HHS-4, HP-16.15

Goal 1, Performance Measure 1:

In terms of Fetal Alcohol Syndrome (FAS) prevention, much has been accomplished since the new objective on FAS prevention was added in 2003. A CDC-funded study identified women at risk for an alcohol-exposed pregnancy in several community-based settings, including a large urban jail and primary care clinics serving low-income women. Researchers found that providing motivational counseling to such women reduced their risk by two-thirds. A randomized controlled trial of this intervention is now underway. Two additional epidemiologic and intervention studies related to alcohol use and pregnancy among Hispanic women are also being implemented. In addition, targeted media campaigns geared toward specific multicultural populations are underway in Missouri, Iowa, and California. Training and educational materials for professionals in health and social service agencies, law enforcement, and school systems are also being developed.

To enhance professionals' knowledge of FAS, CDC has funded four FAS regional training centers located around the country to provide information and education to physicians, nurses, and other allied health professionals about FAS. In addition, CDC's congressionally mandated National Taskforce on FAS and Fetal Alcohol Effects recently published recommendations to improve early detection of FAS, services for children and adults already living with the condition, and services for women at high-risk of having an alcohol-exposed pregnancy. In July 2004, CDC released guidelines for the referral and diagnosis of FAS which will help advance the field of FAS diagnosis and provide clinicians with an opportunity to intervene with women at risk of having a subsequent alcohol-affected pregnancy. This combination of activities, along with enhanced monitoring efforts, is expected to position CDC to achieve its performance targets, particularly in areas where the full breadth of programs are offered (monitoring, research, prevention, and intervention).

Goal 1, Performance Measure 2:

Fortification of the food supply with folic acid (a B vitamin) has allowed major reductions in the rates of serious birth defects of the spine (spina bifida) and brain (anencephaly). However, more reductions are possible if all women of reproductive age consume adequate amounts of folic acid before and during pregnancy. Because Hispanic women have the highest rates of neural tube defects, CDC has made reaching these women a top priority. Preliminary results show that a targeted Spanish-language campaign raised Hispanic women's knowledge of the benefits of folic acid, when they should take it, and even more importantly, has increased actual consumption of folic acid in campaign markets. If results bear true, CDC will work to expand the campaign to reach more Hispanic women and others at high risk. In addition, CDC recently published data documenting the effectiveness of folic acid fortification in preventing spina bifida and anencephaly. Data from birth defects monitoring programs showed that, as a result of fortification, approximately 1,000 more babies are born without these defects each year.

Goal 1, Performance Measure 3:

Increasing the number of births covered by monitoring programs increases the quality of the data, which can then be used more effectively to draw programmatic and scientific conclusions. Mature birth defects tracking programs can achieve results because data that is more representative can be more effective. Establishing prevalence rates will

help CDC to more effectively allocate resources, develop prevention strategies, and evaluate the effectiveness of prevention efforts. Similarly, the ability to detect regional differences in prevalence rates will give CDC important clues about risk factors and causes of birth defects. CDC is working to increase the number of births covered by birth defects monitoring programs, and publishes data from these programs in its annual congenital malformations report.

GOAL 2: IMPROVE THE HEALTH AND QUALITY OF LIFE OF AMERICANS WITH DISABILITIES.			
Performance Measure	Targets	Actual Performance	Ref
1. By 2010, decrease to 10% the percentage of newborns that screen positive for hearing loss but are lost to follow-up. [O]	FY 2006: 22% FY 2005: 25% FY 2004: 30% FY 2003: 35%	FY 2006: 12/2008 FY 2005: 12/2007 FY 2004: 12/2006 FY 2003: 12/2005 FY 2002: 36.6% (Baseline)	HHS-5, HP-28.11
2. Decrease the overall health disparity experienced by people with disability by increasing the number of states that implement a health promotion program to improve the health and quality of life for persons with disabilities.	FY 2006: 20 FY 2005: 8 FY 2004: 7 FY 2003: 6 FY 2002: 5	FY 2006: 10/2006 FY 2005: 10/2005 FY 2004: 25 (Exceeded) FY 2003: 17 (Exceeded) FY 2002: 10 (Exceeded)	HHS-3, 6, HP-6.1-13

Goal 2, Performance Measure 1:


CDC is collaborating with the Health Resources and Services Administration (HRSA) to help states implement the new Early Hearing Detection and Intervention (EHDI) program. CDC helps states establish programs to track children who screen positive for hearing loss and ensure that these children get follow-up diagnostic testing and, if needed, enter early intervention programs. At this early stage in the program, CDC is targeting their efforts to measure the impact of the first and second phases in this process (and have revised the baseline accordingly) – to track the number of children initially screened for hearing loss in the hospital and the number evaluated by a trained audiologist to confirm or deny screening results. Even this seemingly small step involves multiple places where children with hearing loss can be “lost to follow-up,” and is essential for the achievement of targets. To help reduce the burden on states and create a central source of data, CDC has begun working with key partners to design and distribute a standardized form to gather aggregate level EHDI-related data, including “lost to follow-up.”

Goal 2, Performance Measure 2:

CDC supports research and other programs to improve health and quality of life among people of all ages with disabilities. The primary goals of the research component are to identify risk and protective factors, develop effective prevention strategies, and assess the cost-effectiveness of health promotion interventions. One such intervention, “Living Well with a Disability,” has proven to improve health and reduce medical costs and is now being implemented in 17 states. This intervention demonstrates the relationship between CDC-funded research and the translation of this research into public health programs.

HEALTH INFORMATION AND SERVICE

HEALTH STATISTICS

EFFICIENCY MEASURE	TARGETS	ACTUAL PERFORMANCE	REF.
1. Deliver timely data to the nation's health decision-makers. [E]	a) Reduce data release time lags. FY 2006: Reduce time lags for release of core data systems by 5%; National Health Interview Survey (NHIS): Release quarterly 2006 data in 6 months from end of data collection year FY 2005: Same as above FY 2004: Same as above FY 2003: National Health Interview Survey (NHIS): Release 2003 preliminary data in 6 months from end of data collection year	FY 2006: 11/2006 FY 2005: 11/2005 FY 2004: Met FY 2003: Met	HHS-8, HP-1, 2, 3, 5, 6, 7, 8, 9, 12, 13, 14, 15, 16, 17, 18, 19, 21, 22, 23, 24, 25, 26, 27, 28,  -4
	b) Make statistics Internet-accessible FY 2006: Make health statistics Internet-available, including the development of one new product FY 2005: Same as above FY 2004: Same as above FY 2003: Same as above	FY 2006: 11/2006 FY 2005: 11/2005 FY 2004: Met FY 2003: Met	
	c) Produce publications. FY 2006: Produce reports and publications that document trends, issues, and problems in health. FY 2005: Same as above FY 2004: Same as above FY 2003: Same as above	FY 2006: 11/2006 FY 2005: 11/2005 FY 2004: Met FY 2003: Met	

Efficiency Measure 1:

a) Reduce data release time lags.

Because the National Health Interview Survey (NHIS) is conducted throughout the year, yielding a nationally representative sample each week, data can be analyzed weekly or quarterly to monitor health insurance coverage trends and other selected estimates. To date, CDC has the most current health insurance data in the Nation. In FY 2004, NHIS continued to have the most recent health insurance coverage data, as well as quarterly trend data on selected topics, such as data on usual place to go for medical care, influenza and pneumococcal vaccinations, and the prevalence of smoking for adults. Trend data through January – March 2004 was released in September 2004. Trend data through June 2004 was released in December 2004.

CDC substituted the Early Release of Selected Estimates from the NHIS as CDC's example for this efficiency measure. The Early Release of Selected Estimates from the NHIS is a more accurate measure of CDC's efforts to improve timeliness, as it represents work done by CDC (rather than work done, in part, by partners outside of CDC's control). The Vital Statistics timeliness no longer represents a measure of CDC's efforts or performance, as timeliness has been impacted by factors outside of CDC's control.

b) Make statistics Internet accessible.

In FY 2004, CDC achieved continued improvements in technological advances, such as the use of the Internet to make data more timely and accessible. Virtually all CDC publications are available on the Internet concurrent with their release in published form.

All CDC data are now available, from 1968 to the present, on CD-ROM. CDC also recently made its website accessible to visually impaired data users. Other efforts are being made to increase the accessibility and usability of the data systems and website for disabled people.

Internet-only releases, such as Health E-Stats and the Early Release of NHIS, with data through June 2004 released in December 2004, help make CDC's data more accessible to the public. *Health, United States, 2004*, released in December 2004, is available online and has been mailed to data users. *Health, United States, 2005* is scheduled to be released in September 2005.

c) Produce publications.

In FY 2004, CDC continued to lead the efforts to produce America's Children in Brief: Key National Indicators of Well-Being 2004, which was released in July 2004. The report, in its new condensed form, contains data on key indicators of children's health in the U.S. monitored through federal statistics covering areas related to health, economic security, behavior, education, and social and physical environment. This report reveals that birth rates for adolescents continue to decline, victimization rates for youths and violent crime offending rates by youths are down, and high school advanced course-taking rates are the highest levels of the past 20 years.

GOAL 1: MONITOR TRENDS IN THE NATION'S HEALTH THROUGH HIGH-QUALITY DATA SYSTEMS AND DELIVER TIMELY DATA TO THE NATION'S HEALTH DECISION-MAKERS.			
Performance Measure	Targets	Actual Performance	Ref
1. Monitor the nation's health through high-quality data systems.	<p>a) Conduct on-going surveys FY 2006: Conduct four ongoing surveys and data systems that produce detailed trend data for monitoring health FY 2005: Same as above FY 2004: Same as above FY 2003: Same as above</p> <p>b) Increase participant response rates FY 2006: Increase and maintain 78% participation for NHANES through improved outreach with communities, constituents, states and policy makers FY 2005: Same as above FY 2004: Same as above FY 2003: Same as above</p> <p>c) Work with partners FY 2006: Work with NAPHSIS and other partners on efforts to implement electronic death registration systems to improve the timeliness and accuracy of vital health data FY 2005: Same as above FY 2004: Same as above FY 2003: Same as above</p>	<p>FY 2006: 11/2006</p> <p>FY 2005: 11/2005 FY 2004: 4 (Met) FY 2003: 4 (Met)</p> <p>FY 2006: 11/2006</p> <p>FY 2005: 11/2005 FY 2004: 75% (Unmet) FY 2003: 75% (Unmet) FY 2002: 78% (Baseline)</p> <p>FY 2006: 11/2006</p> <p>FY 2005: 11/2005 FY 2004: Met FY 2003: Completed work on models, standards, and specifications needed to develop re-engineered vital statistics systems (Met)</p>	HHS-5

Goal 1, Performance Measure 1:

a) Conduct ongoing surveys.

In FY 2004, all four targeted data systems were operating and producing detailed trend data for monitoring health. For example, one system, the National Health and Nutrition Examination Survey (NHANES), interviewed and examined approximately 6,300 individuals in 15 scientifically-selected communities across the nation to generate national estimates. The National Nursing Home Survey, a component of the National Health Care Survey, began surveying long term care providers for the first time since 1999.

b) Increase participant response rates.

NHANES achieved a 75 percent response rate through outreach with communities, constituents, states, and policy makers. CDC expects their response rates will fluctuate from year to year as a result of the sample design and current conditions, and that the cumulative response rate over six years of the survey will be maintained between 77 to 78 percent.

c) Work with partners.

In FY 2004, CDC continued to work with the National Association for Public Health Statistics and Information Systems (NAPHIS), individual states, and other agencies including the Social Security Administration (SSA) to advance the re-engineering of the nation's vital statistics system. This ongoing project reached several key milestones with the development of technical specifications for electronic systems that can be followed by states and their vendors in the development of systems.

PUBLIC HEALTH INFORMATICS

GOAL 1: DEVELOP A NATIONAL, INTEGRATED, STANDARDS-BASED PUBLIC HEALTH SURVEILLANCE INFRASTRUCTURE THAT IS SECURELY LINKED TO HEALTHCARE PRACTICE.			
Performance Measure	Targets	Actual Performance	Ref
1. Conduct pilot projects to develop and test electronic linkages between public health agencies and the healthcare sector.	FY 2003: Fund 10 states	FY 2003: 10 (Met) FY 2002: 19 states (Baseline)	HHS-5, HP-23, -4
2. Increase the number of states using electronic laboratory reporting.	FY 2003: 40 states	FY 2003: 40 states (Met) FY 2002: 34 states (Baseline)	HHS-5, HP-23, -4

Goal 1, Performance Measure 1:

In FY 2003, Version 1.0 of the NEDSS Base System was delivered and is currently operating in Nebraska and undergoing integration testing in Tennessee, South Carolina, and Louisiana. This measure will be retired after data are reported for FY 2003.

Goal 1, Performance Measure 2:

In FY 2003, CDC continued to support electronic message development, membership in public health standards organizations, and integration of disease-specific systems into the NEDSS architecture. NEDSS compatible Program Area Modules for Hepatitis, Vaccine-Preventable Diseases, Bacterial Meningitis, and Invasive Respiratory Diseases are included in the current version of the NEDSS Base System. This measure will be retired after data are reported for FY 2003.

HEALTH MARKETING

EFFICIENCY MEASURE	TARGETS	ACTUAL PERFORMANCE	REF.
1. Provide "just-in-time" scientific information and education via distance learning to thousands of health professionals, thereby reducing the cost and time delay of traditional educational strategies. [E]	FY 2006: 5% increase from previous year in number of participants registered in distance learning activities. FY 2005: 5% increase in number of participants registered in distance learning activities.	FY 2006: 12/2006 FY 2005: 12/2005 FY 2003: 84,112 participants registered in distance learning activities (Baseline)	HHS-2, 5, HP-23


Efficiency Measure 1:

The most important tool for frontline practitioners is current, “just-in-time” information and knowledge. Public health and healthcare information must be continuously updated, translated, and communicated to meet changing conditions and changing threats. Further, information must be available in the form most useful and accessible to health professionals. To meet these needs, CDC is maintaining systems for information and knowledge transfer, and ensuring that scientific and medical information is translated and communicated effectively and that the best practices of public health professionals are shared nationwide. A target has been established to ensure rapid dissemination of “just-in-time” scientific information and education via distance learning.

GOAL 1: BY 2006, CDC WILL DEVELOP AND IMPLEMENT TRAINING TO PROVIDE FOR AN EFFECTIVE, PREPARED, AND SUSTAINABLE HEALTH WORKFORCE ABLE TO MEET EMERGING HEALTH CHALLENGES.			
Performance Measure	Targets	Actual Performance	Ref
1. Increase the number of interventions adopted by state health officers that were recommended by the Community Guide.	FY 2006: Establish baseline	FY 2006: 6/2007	HHS-5, HP-23, PART

Goal 1, Performance Measure 1:

The Community Guide Surveillance Survey is a web-based survey of Guide awareness and use within key audiences at the state and local levels of the public health community. Developed by Research Triangle Institute in consultation with Community Guide staff, the 18-item questionnaire is expected to generate information for improving both the Guide and its distribution. Pending the successful completion of this pilot project, CDC hopes to re-administer the survey annually or biennially. The Community Guide Surveillance survey will establish this baseline and will be fielded in 2006 pending OMB review. The package was sent to OMB in September 2004, and CDC is awaiting its review.

GOAL 2: INCREASE THE NUMBER OF FRONTLINE PUBLIC HEALTH WORKERS AT THE STATE AND LOCAL LEVEL THAT ARE COMPETENT AND PREPARED TO RESPOND TO BIOTERRORISM, INFECTIOUS DISEASE OUTBREAKS, AND OTHER PUBLIC HEALTH THREATS AND EMERGENCIES; AND PREPARE FRONTLINE STATE AND LOCAL HEALTH DEPARTMENTS AND LABORATORIES TO RESPOND TO CURRENT AND EMERGING PUBLIC HEALTH THREATS.			
Performance Measure	Targets	Actual Performance	Ref
1. Expand frontline public health practitioners' access to Internet-based, CDC-approved public health practice guidelines, scientific/disease reference images, health and medical data, and information on the effectiveness of public health interventions.	<p>FY 2006:</p> <ul style="list-style-type: none"> a) Expand PHIL links to “just in time” programs by 15. b) Transition the Local Health website to a PHIN portal. <p>FY 2005:</p> <ul style="list-style-type: none"> a) Expand PHIL links to “just in time” programs to 50 (Baseline: 35, 05/2004) b) Expand PHIL by 3,000 images c) Design customizable functionality for the Local Health website. <p>FY 2004: Expand PHIL by 3,000 images.</p>	<p>FY 2006:</p> <ul style="list-style-type: none"> a) 12/2006 b) 8/2006 <p>FY 2005:</p> <ul style="list-style-type: none"> a) 10/2006 b) 10/2005 c) 8/2005 <p>FY 2004: 6,150 (Unmet)</p> <p>FY 2003: 4000 images (Baseline)</p>	HHS-4, HP-23,  -5

Goal 2, Performance Measure 1:

The Public Health Image Library (PHIL) is a unique online gallery of scientific photographs, electronic images, videos, and other objects representing significant public health visual information. Clinicians, scientists, researchers, publicists, teachers, students, and the public can access PHIL and obtain images depicting everything from microorganisms to mosquitoes, rashes to risk factors. In FY 2003, 6,150 images were digitized, referenced and archived in PHIL. The target is for approximately 3,000 additional images to be introduced each year, and this is shown as unmet for FY 2004. However, a separate output measure was developed by PHIL in FY 2004, estimating that the number of PHIL images would total 5,500 by the end of 2004. That separately developed estimate was met and exceeded (6,150).

ENVIRONMENTAL HEALTH AND INJURY

ENVIRONMENTAL HEALTH

EFFICIENCY GOAL: PROMOTE EFFECTIVE AND EFFICIENT NCEH MANAGEMENT

Efficiency Measure	Targets	Actual Performance	Ref
1. By 2006, achieve a 20% cost savings and reduce the number of committee members from 28 to 16 as a result of the consolidation of the Advisory Committee to the Director, NCEH and the Board of Scientific Counselors, ATSDR. [E]	FY 2006: 20%/16 members FY 2005: 10%/21 members	FY 2006: 10/2006 FY 2005: 10/2005 FY 2003: \$225,765 in savings; 28 members (Baseline)	HHS-8

Efficiency Measure 1:

ATSDR's Board of Scientific Counselors (BSC) and CDC's Advisory Committee merged in December 2004. This consolidation decreased the total number of board members from 28 to 21. The joint group decided to decrease the number of members to 16 by FY 2006. This reduction will result in a 10% cost savings in FY 2005 and 20% in FY 2006.

GOAL 1: DETERMINE HUMAN HEALTH EFFECTS ASSOCIATED WITH ENVIRONMENTAL EXPOSURES.

Performance Measure	Targets	Actual Performance	Ref
1. By 2006, measure and report the exposure of the U.S. population to 180 environmental chemicals.	FY 2006: 180 FY 2005: 150 FY 2004: 150	FY 2006: 12/2006 FY 2005: 12/2005 FY 2004: 150 (Met)	HHS-1, 2, HP-8.24, 8.25
2. By 2006, complete 30 assessments examining the possible association between a health effect, and an environmental exposure and/or hazard.*	FY 2006: 17 FY 2005: 13 FY 2004: 0	FY 2006: 12/2006 FY 2005: 12/2005 FY 2004: 3 (Exceeded)	HHS-4, 5, HP-8.28
3. By 2006, complete 15 studies to determine the harmful health effects from environmental hazards.*	FY 2006: 7 FY 2005: 6 FY 2004: 2	FY 2006: 12/2006 FY 2005: 12/2005 FY 2004: 27 (Exceeded)	HHS-4, HP-8.26

* Target figures are cumulative for these measures.

Goal 1, Performance Measure 1:

Currently, CDC can measure at least 300 chemicals or their metabolites in human blood or urine. However, not all of these are yet measured in specimens obtained from participants in the National Health and Nutrition Examination Survey (NHANES). In *CDC's Second Report on Human Exposure to Environmental Chemicals*, CDC reported on 116 chemicals. For FY 2004, CDC will provide data on 150 chemicals.

Goal 1, Performance Measure 2:

The National Environmental Public Health Tracking Program is funding 12 states and one local health department (a total of 17 grants) to conduct data linkage demonstration projects. All states originally funded in FY 2002 are expected to complete their demonstration projects in FY 2005. To date, three linkage projects have been completed.

Missouri has completed two data linkage projects:

- **Linkage of child blood lead levels with information on demolition of structures built prior to 1978.** This required linking the existing childhood lead database, St. Louis City Demolition Database, Historic Preservation Records and tax information, Census Data, and Medicaid data. A total of 14 different databases were used in completing the project. The state assessment indicated a statistically significant (though not clinically significant) relationship between children's blood levels and the distance of their residence to a demolition site. Tulane is following up on this finding with an epidemiological study that includes additional data and more in-depth analyses. Findings of this study were presented to representatives of the St. Louis City Health Department, Building Department and Mayor's staff in

December. The goal was to provide information useful to the City in implementing their Lead Safe St. Louis Plan, specifically relating to safe work practices and containment procedures at demolition sites. The Public Safety Commissioner has asked the MO Department of Health for additional analyses to assess the efficacy of recent demolition procedural changes on reducing the potential for child lead exposures.

- **Linkage of data to examine the public health risk of using tailing high in lead and cadmium from the Elvins/Rivermines in St. Francois County as agricultural lime.** Using Arc View GIS and working with ATSDR, Missouri Tracking staff determined the distribution of crop and grassland areas in the county, testing in urban and rural areas of the county, and the spatial distribution of elevated blood lead cases for children under 72 months of age who resided in crop or grassland areas. Results demonstrated the utility of GIS in “linking” specific health data and measures of possible exposure. Results did not show any specific health risk for further follow-up.

New York City (NYC) has completed one data linkage project to examine the relationships among poor housing quality, asthma, and reports of mold. NYC found positive, and statistically significant associations between rates of mold reports and higher rates of poor housing quality, age of building, and asthma attack rates. This effort demonstrated that linking disparate datasets and mapping the results creates a more complete picture of environmental issues and a useful tool for measuring health indicators over time than relying exclusively on single indicators. This linkage among housing quality, health and complaint data exemplifies the objectives of the Environmental Public Health Tracking program.

Goal 1, Performance Measure 3:

Twenty-seven studies were completed (however, final publications are still pending in some cases). Many of these studies were responses to specific state requests.

Sample of publications and completed studies include:

- Persistence of pharmaceutical compounds and other organic wastewater contaminants in a conventional drinking-water-treatment plant: Science of the Total Environment, v. 329, no. 1-3, p. 99-113.
- Occurrence and fate of organic wastewater compounds in the Chattahoochee watershed, Georgia.
- Human exposure to aerosolized brevetoxins during Florida red tide events.
- Study of risk factors for microbial contamination of produce in agricultural fields and packing sheds using epidemiologic methods and environmental and product sampling.
- Health impact assessment of water and sanitation infrastructure reconstruction programs in 11 Central American communities affected by Hurricane Mitch.
- Pesticide exposure in children living in agricultural areas along the U.S.-Mexico Border, Yuma County, AZ.
- Assessment of brief elemental mercury exposure in a Middle School using surveys and urine mercury levels obtained from 200 students—Nevada, 2004.
- Rapid Assessment of the Needs and Health Status of Older Adults After Hurricane Charley - Charlotte, DeSoto, and Hardee Counties, Florida, August 27-31, 2004. MMWR 2004;53:837-840.
- An assessment of Mercury Exposure in Young Children Residing in Chicago communities.
- Kenya Aflatoxin Investigation (number of related studies/reports).
- An investigation of Ackee Fruit Poisoning in Haiti and Review of Ackee Toxicity.

GOAL 2: PREVENT OR REDUCE ILLNESSES, INJURY, AND DEATH RELATED TO ENVIRONMENTAL RISK FACTORS

Performance Measure	Targets	Actual Performance	Ref
1. By 2006, reduce asthma hospitalizations by 14% in states funded by NCEH to implement comprehensive asthma-control programs. [O]	FY 2006: 14% FY 2005: 12% FY 2004: 10%	FY 2006: 12/2006 FY 2005: 12/2005 FY 2004: Data unavailable	HHS-1, HP-24.2
2. By 2006, reduce the number of children with elevated BLLs by 58%. [O]	FY 2006: 58% FY 2005: 54% FY 2004: 20%	FY 2006: 12/2006 FY 2005: 12/2005 FY 2004: 51% (Exceeded)	HHS-1, HP-8.11

GOAL 2: PREVENT OR REDUCE ILLNESSES, INJURY, AND DEATH RELATED TO ENVIRONMENTAL RISK FACTORS			
Performance Measure	Targets	Actual Performance	Ref
3. By 2006, prevent the spread of disease and treat malnutrition among refugees in complex humanitarian emergencies in 100% of locales where CDC provides assistance. [O]	FY 2006: 100% FY 2005: 100% FY 2004: 100%	FY 2006: 12/2006 FY 2005: 12/2005 FY 2004: 100% (Met)	HHS-2, HP-8.29, 8.30
4. By 2006, increase the capacity of 50% of state, local, and tribal agencies for which CDC provides assistance to prevent the spread of outbreaks from food- and water-borne illness.	FY 2006: 50% FY 2005: 25% FY 2004: 12.5%	FY 2006: 12/2006 FY 2005: 12/2005 FY 2004: 56% (Exceeded)	HHS-2, HP-8.27, 8.29

Goal 2, Performance Measure 1:

CDC aims to reduce hospitalizations due to asthma by helping state coalitions create comprehensive asthma-control programs that include building and using tracking systems to track asthma and using that data to provide interventions to people most in need, thereby preventing hospitalizations and other adverse health effects of asthma. This program effort is being measured by direct target goals set by *Healthy People 2010* and driven by HHS' strategic goal to "reduce the major threat to the health and well being of all Americans."

EHHE funded 35 state/city/territory grantees in FY 2004 to develop or implement comprehensive asthma control programs. Six of these grantees (Michigan, New York, Oregon, California, Illinois, and Minnesota) are funded to fully implement their asthma control program. This measure is based on the HP 2010 goal of reducing hospitalizations for asthma (goal 24.2). National surveillance data for hospitalizations (source HP2010) and state-based hospitalization data for 2004 will be available in the next 18 – 24 months. The baseline for comparison will be available later in FY 2005.

Goal 2, Performance Measure 2:

The *Second National Report on Human Exposure to Environmental Chemicals* quantified the effectiveness of national, state and local efforts to reduce blood lead levels (BLLs) in young children (ages one to five years). The percentage of such children with BLLs over 10 ug/dl has decreased from an estimated 4.4 percent in NHANES III (1991–1994) to the 2.2 percent estimated in the *Second Report* (1999–2000). This decline indicates that lead exposure among young children in the general population is diminishing.

The 2001-2002 NHANES estimate is approximately 211,000 (1.07 percent) of children aged one to six had BLLs above 10 ug/dL, a 51 percent decline in the number of children with elevated BLLs. This figure should be interpreted cautiously because the NHANES estimates are based on small numbers of children with blood lead levels $\geq 10\mu\text{g/dL}$ and there is limited experience comparing estimates based on intervals containing only two years of data instead of the four preferred by CDC. The FY 2006 target for this measure has been revised upward because the program already surpassed the original FY 2006 target of 46 percent during FY 2004.

Goal 2, Performance Measure 3:

The International Emergency and Refugee Health (IERH) program coordinates CDC's response to complex humanitarian emergencies, such as technical assistance to other federal agencies, the United Nations, and other organizations in areas related to the health of refugee populations. Because of early emergency phase interventions, disease outbreaks are assessed to prevent their spread among refugees in complex humanitarian emergencies where CDC provides assistance. The nationwide measles campaign in Liberia has to date successfully immunized 1.3 million children with coverage surveys estimating over 90 percent of children being vaccinated. On the basis of the number of children susceptible to measles prior to the campaign, an estimated 20,000 deaths among children less than five years of age have been averted by this campaign.

Goal 2, Performance Measure 4:

CDC currently works with 427 state and local environmental health service delivery programs to increase their capacity to prevent the spread of outbreaks from food and water borne illness. Some examples of this support are:

- Supported with technical assistance, funds, and training eight states in EHS-NET activities that collect, analyze, and disseminate information on the factors that most likely contribute to foodborne illness and outbreaks.
- Provided guidance during technical assistance efforts to 10 states relating to drinking water and recreational water supplies.
- Funded five state and local health departments to build or enhance environmental health services capacity built on the Ten Essential Public Health Services framework.

GOAL 3: BUILD AND ENHANCE EFFECTIVE PARTNERSHIPS TO IMPROVE ENVIRONMENTAL HEALTH CAPACITY.			
Performance Measure	Targets	Actual Performance	Ref
1. Provide assistance to 20 partners.	FY 2006: 20 FY 2005: 20 FY 2004: 20	FY 2006: 12/2006 FY 2005: 12/2005 FY 2004: 20 (Met)	HHS-4, 5, HP-8.20, 8.21

Goal 3, Performance Measure 1:

CDC continues to develop active partnerships through direct funding and through earmarks monitored by the Center. The following list groups partners by funding source:

CDC Partnerships with National Organizations :

- | | |
|---|---|
| <ul style="list-style-type: none"> • National Healthy Homes Training Center and Network • Eastern Kentucky University • State Medicaid Agencies • World Health Organization • United Nations Commissioner on Refugees • World Food Program • National Environmental Health Association • Association of Public Health Laboratories • The Immune Deficiency Foundation • Columbia University | <ul style="list-style-type: none"> • University of California at Berkeley • Mt. Sinai School of Medicine • Environmental Protection Agency • National Aeronautics and Space Administration • U. S. Geological Survey • University of Miami • National Institutes of Health • National Oceanic and Atmospheric Administration • Lovelace Respiratory Research Institute (Albuquerque, NM) • U.S. Coast Guard |
|---|---|

INJURY PREVENTION AND CONTROL

EFFICIENCY MEASURE	TARGETS	ACTUAL PERFORMANCE	REF.
1. Through the implementation of Web-based systems for state and territorial agencies, decrease the time between the submission of an application and the receipt of funds for injury prevention and control efforts. [E]	FY 2006: Maintain FY 2005 Efficiency FY 2005: 5% faster FY 2004: Establish baseline	FY 2006: 12/2007 FY 2005: 12/2006 FY 2004: 12/2005	HHS-8, -3, 4

Efficiency Measure 1:

With an initial investment to develop the system, efficiencies are created when applications are received and processed more quickly. A Web-based system also allows retrieving and summarizing grantee information faster and better than what can be collected otherwise. In addition to the time saved, this measure also improves customer

service. As more applications become standardized, and grantees become more familiar with their format, the grant application process will require less time and provide for more efficient means of tracking and monitoring the status of submissions.

GOAL 1: INCREASE THE CAPACITY OF INJURY PREVENTION AND CONTROL PROGRAMS TO ADDRESS THE PREVENTION OF INJURIES AND VIOLENCE.			
Performance Measure	Targets	Actual Performance	Ref
1. Reduce the incidence of rape or attempted rape. [O]	FY 2006: Under development FY 2005: Creating annual milestones FY 2004: Establish baseline	FY 2006: 12/2007 FY 2005: 12/2006 FY 2004: 12/2005	HHS-1, HP-15.35
2. Among the states receiving funding from CDC, reduce deaths from residential fire. [O]	FY 2006: 1.27 per 100,000 FY 2005: 1.28 per 100,000 FY 2004: 1.29 per 100,000 FY 2003: 1.30 per 100,000 FY 2002: 1.31 per 100,000	FY 2006: 10/2008 FY 2005: 10/2007 FY 2004: 10/2006 FY 2003: 10/2005 FY 2002: 1.15 per 100,000 (Exceeded) FY 2001: 1.26 per 100,000 (Baseline)	HHS-1, HP-15.25

Goal 1, Performance Measure 1:

CDC is developing a measure to track its performance in the rape prevention and education program. A baseline will be established on the number of school and college aged people reached through programs supported by the Rape Prevention and Education Program by collecting data from grantees through the Rape Prevention and Education Grants System.

Goal 1, Performance Measure 2:

Residential fire deaths, among states receiving funding for residential fire prevention activities, were reduced to 1.15/100,000 people, which exceeds the target for FY 2002.

GOAL 2: MONITOR AND DETECT FATAL AND NON-FATAL INJURIES.			
Performance Measure	Targets	Actual Performance	Ref
1. Increase the number of states receiving CDC funding to monitor, identify, and track injuries.	a) TBI Surveillance FY 2006: Maintain FY 2005 state funding levels to continue implementing TBI surveillance FY 2005: Maintain FY 2004 state funding levels to continue implementing TBI surveillance FY 2004: Disseminate TBI data at state level FY 2003: Revise Central Nervous System (CNS) surveillance guidelines to include protocols for collecting data on mild TBI	a) TBI Surveillance FY 2006: 2/2006 FY 2005: 2/2005 FY 2004: Met FY 2003: Met	HHS-5, HP-15.1, 15.10

GOAL 2: MONITOR AND DETECT FATAL AND NON-FATAL INJURIES.			
Performance Measure	Targets	Actual Performance	Ref
	b) NEISS All Injury Surveillance FY 2006: Maintain FY 2005 activities FY 2005: Provide national statistics via an Internet-based electronic reporting system made available to the public FY 2004: Publish national statistics on non-fatal injuries treated in emergency departments by leading causes of injury FY 2003: Implement an NEISS All Injury Program special study on traumatic brain injury c) NVDRS Surveillance FY 2006: Maintain FY 2005 state funding levels to continue implementing NVDRS FY 2005: Maintain FY 2004 state funding levels to continue implementing NVDRS FY 2004: Maintain FY 2003 state funding levels to continue implementing NVDRS FY 2003: Increase the number of states implementing NVDRS from 6 to 8	b) NEISS All Injury Surveillance FY 2006: 12/2006 FY 2005: 12/2005 FY 2004: Met FY 2003: Met c) NVDRS Surveillance FY 2006: 12/2006 FY 2005: 12/2005 FY 2004: 17 states funded (Exceeded) FY 2003: 13 states funded (Exceeded)	

Goal 2, Performance Measure 1:

a) Traumatic Brain Injury (TBI) Surveillance – CDC funds 11 state health departments to report the number of people who die or are hospitalized with a TBI. Surveillance information was disseminated among the participating states, achieving the target.

b) National Electronic Injury Surveillance System (NEISS) – NEISS, funded by CDC in collaboration with the U.S. Consumer Product Safety Commission (CPSC), provides injury data from inner city, urban, suburban, and rural children’s hospitals. CDC uses NEISS data to generate national estimates of nonfatal injuries in the U.S. and to guide decisions and policies about injury prevention and control. National statistics on non-fatal injuries treated in emergency departments by leading causes of injury were published, meeting the target for FY 2004.

National Violent Death Reporting System (NVDRS) – In FY 2004, CDC funded 17 states to implement NVDRS, gathering and sharing state-level data about violent deaths. This state-based system collects data from medical examiners, coroners, police, crime labs, and death certificates to understand the circumstances surrounding violent deaths. This information can be used to develop, inform, and evaluate violence prevention programs and exceeded the target established for FY 2004.

GOAL 3: CONDUCT A TARGETED PROGRAM OF RESEARCH TO REDUCE INJURY-RELATED DEATH AND DISABILITY.



Performance Measure	Targets	Actual Performance	Ref
1. Develop new or improved approaches to prevent and control death and disability due to injuries.	<p>FY 2006: Maintain FY 2005 funding level for research agenda targeted areas; peer review 98% of research projects</p> <p>FY 2005: Maintain FY 2004 funding level for research agenda targeted areas; peer review 98% of research projects</p> <p>FY 2004: Maintain FY 2003 funding level for research agenda targeted areas; increase peer-review by 5%</p> <p>FY 2003: Fund one research project for injury research in targeted areas; increase peer-review by 5%</p>	<p>FY 2006: 9/2006</p> <p>FY 2005: 9/2005</p> <p>FY 2004: Maintained funding for targeted areas, 93% of research awards peer-reviewed (Exceeded)</p> <p>FY 2003: 90% of research awards peer-reviewed (Exceeded)</p> <p>FY 2002: 66% of research awards peer-reviewed; 134 projects funded (Baseline)</p>	HHS-4, HP-15


Goal 3, Performance Measure 1:

CDC research focuses on reducing morbidity, disability, death, and lowering costs associated with injuries. CDC's extramural research program supports the following:

- 12 research centers for broad-based injury control.
- 10 centers for youth violence prevention and one center for older adult injury prevention.
- Individual, investigator-initiated research that is targeted to specific studies.
- Grants for small business innovative research.

CDC also conducts evaluation research to ascertain the efficacy and effectiveness of interventions and other factors that put people at risk for injury. The extramural program supports a productive and relevant research portfolio and uses a peer review approach that is based on review by the Injury Research Grant Review Committee (IRGRC). IRGRC is composed of experts in injury-related scientific disciplines or current research areas that enable them to

GOAL 1: CONDUCT RESEARCH TO REDUCE WORK-RELATED ILLNESSES AND INJURIES.			
Performance Measure	Targets	Actual Performance	Ref
<p>2. Increase the relevance of occupational safety and health research for future improvements in workplace protection.</p>	<p>FY 2005: Evaluate relevance of first 1/5 of CDC NIOSH program activities with 80% rating 4 or 5 (on a scale of 1 to 5, with 5 being the highest) as judged by independent panels of external customers, stakeholders, and experts.</p> <p>FY 2004: Finalize arrangements with National Academies of Science (NAS) for relevance review.</p> <p>FY 2003: Conduct baseline evaluation among safety and health professionals of CDC NIOSH research relevance for practical workplace results.</p>	<p>FY 2005: 12/2005</p> <p>FY 2004: NAS contract for the review of program activities is in place (Met)</p> <p>FY 2003: Met</p>	<p>HHS-4, HP-20, -5</p>
<p>3. Ensure the quality of occupational safety and health research, as measured by peer review.</p>	<p>FY 2006: 90% of internal research programs and 100% of research grants and cooperative agreements result in peer-reviewed publications within one year of project completion. 80% of new internal research projects and 100% of new research grants and cooperative agreements are reviewed by external peer-review at project inception.</p> <p>FY 2005: 80% of internal research programs and 90% of research grants and cooperative agreements result in peer-reviewed publications within one year of project completion. 70% of new internal research projects and 100% of new research grants and cooperative agreements are reviewed by external peer-review at project inception.</p> <p>FY 2004: 70% of internal research programs and 80% of research grants and cooperative agreements result in peer-reviewed publications within one year of project completion. 60% of new internal research projects and 90% of new research grants and cooperative agreements are reviewed by external peer-review at project inception.</p>	<p>FY 2006: 12/2006</p> <p>FY 2005: 12/2005</p> <p>FY 2004: 63% of internal research projects and 82% of research grants and cooperative agreements ending in FY 2003 resulted in at least one peer-reviewed publication within one year of project completion. (Unmet/Exceeded); 86% of internal research programs and 100% of research grants were externally peer-reviewed (Exceeded)</p>	<p>HHS-4, HP-20, -5</p>

GOAL 1: CONDUCT RESEARCH TO REDUCE WORK-RELATED ILLNESSES AND INJURIES.			
Performance Measure	Targets	Actual Performance	Ref
	<p>FY 2003: 60% of new internal research projects and 70% of research grants and cooperative agreements result in peer-reviewed publications within one year of project completion.</p> <p>40% of new internal research projects and 90% of new research grants and cooperative agreements are reviewed by external peer-review at project inception.</p>	<p>FY 2003: For research projects ending in FY 2002, 62% had at least one peer-reviewed publication within one year of project completion. (Exceeded)</p> <p>60% of new internal research projects and 100% of new research grants and cooperative agreements were externally peer-reviewed. (Exceeded)</p>	
<p>4. Improve the quality and usefulness of tracking information for safety and health professionals and researchers in targeting research and intervention priorities; and measure the success of implemented intervention strategies.</p>	<p>FY 2006: Continue to evaluate the role that tracking information had in designing research and intervention projects, as well as the role that follow-up tracking information can have in assessing the success of interventions. Heightened use of tracking data as a way to reduce the prevalence rate of elevated blood lead concentrations in persons due to work exposures by 3%.</p> <p>FY 2005: Continue to evaluate the role that tracking information had in designing research and intervention projects, as well as the role that follow-up tracking information can have in assessing the success of interventions. Heightened use of tracking data as a way to reduce the prevalence rate of elevated blood lead concentrations in persons due to work exposures by 3%.</p> <p>FY 2004: Evaluate the role that tracking information had in designing research and intervention projects, and the role that follow-up tracking information can have in assessing the success of interventions. Heightened use of tracking data as a way to reduce the prevalence rate of elevated blood lead concentrations in persons due to work exposures by 3%.</p>	<p>FY 2006: 03/2007</p> <p>FY 2005: 03/2006</p> <p>FY 2004: 153 research and intervention projects were based on tracking information; 21 intervention programs used tracking information to demonstrate the success of the intervention strategy; 3% reduction in the prevalence rate of elevated blood lead levels in adults, 16 and older (9.3 adults per 100,000) (Met)</p>	<p>HHS-4, HP-20.7, -5</p>

GOAL 1: CONDUCT RESEARCH TO REDUCE WORK-RELATED ILLNESSES AND INJURIES.			
Performance Measure	Targets	Actual Performance	Ref
	<p>FY 2003: Establish a baseline by identifying those research and intervention projects that were based upon tracking information</p> <p>Identify CDC NIOSH intervention programs that have used tracking information to demonstrate success of the intervention strategy.</p> <p>Heightened use of tracking data as a way to reduce the prevalence rate of elevated blood lead concentrations in persons due to work exposures by establishing a baseline of the number of persons per 100,000 employed with elevated blood lead levels of 25 mcd/dL or greater.</p>	<p>FY 2003: 187 research and intervention projects were based on tracking information;</p> <p>21 intervention programs used tracking information to demonstrate the success of the intervention strategy;</p> <p>12.0 adults per 100,000 employed (16 and older) with elevated blood lead levels of 25 mcd/dL or greater. (Baseline)</p>	
5. Percentage of NIOSH programs that will have completed program-specific outcome measures and targets in conjunction with stakeholders and customers.	<p>FY 2006: 50%</p> <p>FY 2005: 33%</p>	<p>FY 2006: 9/2006</p> <p>FY 2005: 9/2005</p>	HHS-4, PART

Goal 1, Performance Measure 1:

CDC has entered into a contract with the National Academy of Sciences (NAS) to conduct a comprehensive review of its occupational safety and health research program. By completing a program inventory of all research activities, CDC has identified key areas of research to be evaluated in the first phase of the NAS review.

Goal 1, Performance Measure 2:

CDC conducts research on the full scope of occupational disease and injury, from basic research on mechanisms and etiology of occupational diseases, to applied research on specific ways to prevent disease and injury in the workplace. CDC met its FY 2004 target by contracting with the NAS to assess the relevance and usefulness of its research activities. This measure will be retired after data are reported for FY 2005.

Goal 1, Performance Measure 3:

CDC disseminates its research findings through a variety of publications. In FY 2004, 82% CDC funded research grants and cooperative agreements for occupational safety and health resulted in peer-reviewed publications, exceeding the target. However, fewer internal CDC projects resulted in peer-reviewed publications than targeted. This can be attributed to the lag time between the submission and actual publication of peer-reviewed articles, and the publication of research findings in CDC numbered documents. While peer-reviewed publications are valuable, especially in the dissemination of research findings to occupational safety and health professionals, the use of alternative publications enables CDC to direct their research findings to a broader audience, including employees and employers. This further promotes the translation of research findings into effective prevention practices adopted in the workplace.

In FY 2004, 86 percent of new internal research projects and 100 percent of new research grants and cooperative agreements were externally peer-reviewed at project inception. All new CDC research grants and cooperative agreements are peer-reviewed through the NIH peer-review system. CDC exceeded this portion of the FY 2004 target.

Goal 1, Performance Measure 4:

CDC supports several state-based surveillance activities and maintains national databases of occupational injuries and fatalities. Linked to this health information is the identification of exposures to hazards that can lead to illness and injury. With this information, specific research initiatives can be undertaken to understand the relationships between exposures and health outcomes. In turn, intervention strategies are developed and implemented to reduce illness and injury.

In FY 2004, 153 research and intervention projects were based on tracking information, and 21 intervention programs used tracking information to demonstrate the effectiveness of the programs' strategies. Due to fewer new research and intervention projects beginning in FY 2004, the number of projects based on tracking information is lower than reported in FY 2003. However, CDC continues to reach its performance target.

Although not included in the target, many CDC projects such as training initiatives and information projects are also initiated in response to surveillance information. CDC continuing education courses, CDC Alerts and Fact Sheets may be developed for occupational safety and health professionals, employers and employees to renew concern and present prevention strategies for identified workplace hazards.

To increase tracking capabilities at the state level, CDC collaborated with the Council of State and Territorial Epidemiologists (CSTE) to complete a set of occupational health indicators that are designed to provide information about a population's health status with respect to workplace factors. In 2003, the indicators were piloted by 10 states participating in the CDC's States Occupational Surveillance Consortium (SOSC). In the future, a document with data from selected states will be developed to provide a broad view of occupational safety and health at the state level and differences that exist among states.



Goal 1, Performance Measure 5:

As part of the National Academy of Science (NAS) comprehensive review of research activities referenced in Performance Measure 1, all programs will develop comprehensive outcome-based measures and targets in conjunction with stakeholders and customers. These measures and targets will form the framework for evaluation of the impact of research by NAS, and will establish transparent customer-based targets across the entire portfolio.

INTERVENTIONS, RECOMMENDATIONS AND CAPACITY BUILDING

GOAL 2: PROMOTE SAFE AND HEALTHY WORKPLACES THROUGH INTERVENTIONS, RECOMMENDATIONS AND CAPACITY BUILDING.			
Performance Measure	Targets	Actual Performance	Ref
1. Increase the quality, relevancy, and usefulness of CDC information and recommendations to occupational safety and health professionals, workers, employers, government, the scientific community, and the public.	<p>FY 2006: Increase the number of occupational safety and health professionals who use CDC as a source for occupational safety and health information; continue to establish baseline.</p> <p>FY 2005: Increase the number of occupational safety and health professionals who use CDC as a source for occupational safety and health information; continue to establish baseline.</p> <p>FY 2004: Increase the use of CDC information and recommendations by occupational safety and health professionals, workers, employers, government, the scientific community, and the public.</p> <p>FY 2003: Establish baseline.</p>	<p>FY 2006: 12/2006</p> <p>FY 2005: 12/2005</p> <p>FY 2004: 79% of professionals responding to the survey indicated that they had used or been referred to CDC-NIOSH publications (Met)</p> <p>FY 2003: 74% (Out of 688 professionals who completed the survey, indicating that they had read or referred to occupational safety and health information provided or published by CDC within the last 12 months.) (Baseline)</p>	HHS-4, 4-4, 5
2. Increase the percentage of CDC NIOSH-trained professionals who enter the field of occupational safety and health after graduation.	<p>FY 2006: 80%</p> <p>FY 2005: 75%</p> <p>FY 2004: 70%</p> <p>FY 2003: Establish baseline.</p>	<p>FY 2006: 12/2006</p> <p>FY 2005: 12/2005</p> <p>FY 2004: 75% (Exceeded)</p> <p>FY 2003: 68% (Baseline)</p>	HHS-4, 4-5, PART

GOAL 2: PROMOTE SAFE AND HEALTHY WORKPLACES THROUGH INTERVENTIONS, RECOMMENDATIONS AND CAPACITY BUILDING.			
Performance Measure	Targets	Actual Performance	Ref
3. Increase the percentage of people with occupational safety and health responsibilities who have academic or continuing education training.	<p>FY 2005: Increase number of trained professionals by 6% from baseline.</p> <p>FY 2004: Increase number of trained professionals by 3% from baseline.</p> <p>FY 2003: Establish baseline.</p>	<p>FY 2005: 12/2005</p> <p>FY 2004: 1,512 full-time academic trainees (8 % increase) and 36,917 continuing education trainees (17 % increase) (Exceeded)</p> <p>FY 2003: 1,405 full-time academic trainees and 31,508 continuing education trainees (Baseline)</p>	HHS-4, -5
4. Reduce the annual incidence of work injuries, illnesses, and fatalities, in targeted sectors. [O]	<p>FY 2006: 7% reduction of non-fatal injuries among youth ages 15–17; 9% reduction of fatal injuries among youth 15–17; 5% reduction in the annual number of silicosis deaths among U.S. residents age 15 and older.</p> <p>FY 2005: 5% reduction of non-fatal injuries among youth ages 15–17; 7% reduction of fatal injuries among youth 15–17; 5% reduction in the annual number of silicosis deaths among U.S. residents age 15 and older.</p> <p>FY 2004: 3% reduction of non-fatal injuries among youth ages 15–17; 5% reduction of work-related fatalities among youth ages 15–17; 5% reduction in the annual number of silicosis deaths among U.S. residents age 15 and older.</p> <p>FY 2003: Establish baseline incidence rates of non-fatal injuries and work-related fatalities among youth ages 15–17; establish baseline for the annual number of silicosis deaths among U.S. residents age 15 and older.</p>	<p>FY 2006: 12/2006</p> <p>FY 2005: 12/2005</p> <p>FY 2004: 9.6% reduction in non-fatal injuries among youth 15-17 from baseline (4.7 non-fatal injuries per 100 FTE) (Exceeded); 35.7% reduction in work-related fatalities among youth ages 15-17 from baseline (2.5/ fatalities per 100,000 FTE) (Exceeded); 9.0% reduction in annual number of silicosis deaths among US residents age 15 and older (164 silicosis deaths) (Exceeded)</p> <p>FY 2003: 5.2 non-fatal injuries for youth (emergency department treated injuries and illnesses per 100 FTE in 1999; source: NEISS); 3.5 fatal injuries for youth (deaths per 100,000 FTE; average fatality rate for the period 1992-2000; source: CFOI); 180 silicosis deaths (among U.S. residents age 15 and older; source: 2002 World Surveillance Report, Norms Query System for 2000). (Baseline)</p>	HHS-1, HP-20.1, 20.2, 20.4, -5

GOAL 2: PROMOTE SAFE AND HEALTHY WORKPLACES THROUGH INTERVENTIONS, RECOMMENDATIONS AND CAPACITY BUILDING.			
Performance Measure	Targets	Actual Performance	Ref
5. Increase workplace use of control and personal protective technologies in targeted sectors. [O]	<p>FY 2006: Increase the availability of CBRN-certified respirators for use during a CBRN event to 20% of the professional firefighters; increase the percentage of U.S. pavers with installed engineering controls to 90%.</p> <p>FY 2005: Increase the availability of CBRN-certified respirators for use during a CBRN event to 15% of the professional firefighters; increase the percentage of U.S. pavers with installed engineering controls to 80%.</p> <p>FY 2004: Increase the availability of CBRN-certified respirators for use during a CBRN event to 10% of the professional firefighters; increase the percentage of U.S. pavers with installed engineering controls to 70%.</p> <p>FY 2003: Increase the availability of CBRN-certified respirators for use during a CBRN event to 3% of the professional firefighters; establish baseline percentage of U.S. pavers with installed engineering controls.</p>	<p>FY 2006: 06/2007</p> <p>FY 2005: 06/2006</p> <p>FY 2004: CBRN-certified respirators are available to 7.2% of professional firefighters (Unmet); 70% of U.S. pavers are equipped with installed engineering controls (Met)</p> <p>FY 2003: 3% (Met) 2 additional CBRN approvals were issued during FY 2003 from the International Association of Fire Chiefs, the International Association of Firefighters, and direct contacts with large fire departments (66 fire departments represented); 60% of U.S. pavers are equipped with installed engineering controls (FY 2003 Baseline)</p>	HHS-1, 2  -5
6. Reduce occupational illness and injury as measured by: a) percent reductions in respirable coal dust overexposure; b) percent reduction in fatalities and injuries in roadway construction, and c) percent of firefighters and first responders' access to chemical, biological, radiological, and nuclear respirators. [O]	FY 2014: a) 50% reduction; b) 40% reduction; c) 75%	FY 2014: 12/2014	HHS-1, PART
7. Percentage of a) companies employing those with NIOSH training that rank the value added to the organization as good or excellent; and the percentage of b) professionals with academic or continuing education training. [O]	FY 2009: a) 80%; b) increase of 15%	FY 2009: 12/2009	HHS-4,  -5, PART

Goal 2, Performance Measure 1:

CDC engages in capacity building activities through information dissemination. In FY 2003, CDC assessed its capacity building capabilities through information dissemination by conducting a survey questionnaire of four professional associations. CDC mailed the survey in mid-January to a random sample of 300 members from the American Association of Occupational Health Nurses (AAOHN), American College of Occupational and Environmental Medicine (ACOEM), American Industrial Hygiene Association (AIHA), and American Society of Safety Engineers (ASSE), providing a combined sample size of 1,200. From the 688 completed surveys, CDC's final results

indicate that 79 percent responded affirmatively to reading or referring to occupational safety and health information provided or published by CDC.

Goal 2, Performance Measure 2:

This measure focuses on the effectiveness of CDC training with respect to entry into the field of occupational safety and health. CDC conducts a competitive training grant program aimed at increasing the number of professionals trained to work in the occupational safety and health field. CDC supports a network of Education and Research Centers (ERCs) and Training Project Grants (TPGs) around the country. In FY 2004, 500 professionals graduated from these programs with specialized training in disciplines that include occupational medicine, occupational health nursing, industrial hygiene, occupational safety and occupational injury prevention.

CDC estimates that about half of all U.S. occupational safety and health professionals graduate from CDC-supported programs at the masters and doctoral levels. In FY 2004, CDC exceeded its performance goal with 75% of the professionals graduating from CDC-funded programs pursuing careers in occupational safety and health.

Goal 2, Performance Measure 3:

CDC maintains the national cadre of occupational safety and health professionals by training professionals through extramural funding of ERCs and TPGs. Within ERCs, CDC funds more than 1,000 continuing education courses in occupational safety and health each year. Along with its ERCs, CDC also develops training materials for particular groups, specifically miners and young and new workers.

In conjunction with its capacity building efforts, CDC has evaluated this effort and the nation's capacity most recently through the funding of the Institute of Medicine review and report, *Safe Work in the 21st Century: Education and Training Needs for the Next Decade's Occupational Safety and Health Personnel*. This report will also serve to focus future efforts in CDC's capacity building efforts to achieve future performance targets. This measure will be retired after data are reported for FY 2005.

Goal 2, Performance Measure 4:

CDC translates occupational safety and health surveillance and research findings into technically and economically usable solutions to control workplace hazards and reduce work-related injuries, illnesses, and fatalities.

CDC has a long history of conducting and supporting young worker safety health research and intervention activities, and working with partners to improve young worker safety and health. In 2004, CDC led a federal interagency working group on childhood agricultural injury prevention, and conducted joint outreach with the US Department of Labor (DOL) to provide employers with information on young worker safety in the construction industry. CDC also provided input in the revised child labor regulations announced by the DOL on December 16, 2004. Building upon curricula and teaching tools developed by CDC funded grants and others, CDC is developing a core occupational safety and health curriculum for young workers that engages students and teachers in the exploration of risks to youth in the workplace, their rights and relevant labor laws, common workplace hazards and controls, communication skills, and young workers' role in emergency preparedness and response. Currently, CDC is working with state educational agencies to pilot test this curriculum.

CDC is also actively working to decrease the incidence of silicosis, an irreversible but preventable disease most closely associated with occupational exposure to silica. In partnership with the DOL, CDC has established and promoted recommended exposure limits for silica and implemented the Silicosis Education Campaign. These efforts provide workers and employers in a variety of industries, including construction and mining, with a guide to working safely with the potentially hazardous compound.

Goal 2, Performance Measure 5:

CDC has issued Chemical, Biological, Radiological and Nuclear (CBRN) Air Purifying Respirators (APR) approvals and implemented standards for upgrading traditional firefighter Self Contained Breathing Apparatus (SCBA) to CBRN protection levels. In addition to developing respirator certification standards and user guidelines, CDC is committed to ensuring that CBRN-protective respirators are available to professional firefighters. Although CDC did not meet the FY 2004 target, the availability of CBRN-certified respirators for use during a CBRN event increased to more than seven percent of professional firefighters. Based on reports from the Department of Homeland Security, to date, CDC has increased availability of CBRN-approved respirators to professional firefighters by 7.2 percent, however, fourth quarter data is not yet available. By May 2005, full reporting will be available and it is anticipated that this target will be met.

More than 350,000 U.S. workers are exposed to fumes generated during the manufacture or use of asphalt. Asphalt fumes are known to cause irritation of the eyes and mucous membranes of the respiratory tract, and research is underway to determine if the fumes are occupational carcinogens. CDC's goal is to facilitate the installation of engineering controls on virtually all U.S. highway-class pavers by 2010. CDC will track the percentage of pavers with engineering controls each year, setting yearly targets to achieve 95 percent by 2010.

Goal 2, Performance Measure 6:

For most program activities, reductions in occupational illnesses and injuries are due to multiple factors of which research is one component. However for some sectors and activities, extenuating circumstances are minimal and efforts are at a stage where future decreases in illness and injuries logically can be attributed to the success of programs without requiring the additional level of analysis. This measure targets three such high risk sectors and activities which represent impact in (a) occupational illness (due to coal dust overexposure), (b) occupational injuries (in roadway construction), and (c) preparedness (firefighter access to CBRN respirators).

Goal 2, Performance Measure 7:

The impact of training can be evaluated as a product of two metrics: the number of trained professionals in occupational safety and health positions, and the value of these trainees to their organizations. In addition, a third metric is used to judge the success of training programs based on the satisfaction of trainees. New surveys will be conducted to augment existing data on the impact of training programs. Follow-up surveys with trainees will determine their level of satisfaction with their education, and surveys of companies hiring trainees will judge the impact they are having in the workplace. In addition, efforts will continue to track the number of professionals with occupational safety and health duties that have academic or continuing education training.

GLOBAL HEALTH

GLOBAL AIDS PROGRAM

CDC continues to develop HIV/AIDS prevention, care, and treatment programs in 25 countries and four regional offices around the world. CDC has assigned 100 staff in 25 countries and has hired over 1,000 locally employed staff in host countries. CDC has established over 160 cooperative agreements to extend the scope and reach of its activities. A monitoring and evaluation plan for all activities has been developed and all countries submit annual reports. CDC has worked closely with partners included OGAC, USAID, the World Health Organization (WHO), the World Bank, and others to develop a set of common core indicators of progress.

GOAL 1: BY 2010, WORK WITH OTHER COUNTRIES, INTERNATIONAL ORGANIZATIONS, THE U.S. DEPARTMENT OF STATE, USAID, AND OTHER PARTNERS TO ACHIEVE THE UNITED NATIONS GENERAL ASSEMBLY SPECIAL SESSION ON HIV/AIDS GOAL OF REDUCING PREVALENCE AMONG 15 TO 24 YEARS OF AGE.			
Performance Measure	Targets	Actual Performance	Ref
1. Initiate, expand, or strengthen HIV/AIDS prevention, care, treatment, and support activities globally. (Includes all GAP funding except that specifically dedicated to the PMTCT).	Surveillance	Surveillance	
	FY 2006: 25 countries	FY 2006: 3/2007	
	FY 2005: 25 countries	FY 2005: 3/2006	
	FY 2004: 25 countries	FY 2004: 25 (Met)	
	FY 2003: 25 countries	FY 2003: 25 (Met)	
	FY 2002: 25 countries	FY 2002: 25 (Met)	
	Voluntary counseling and testing	Voluntary counseling and testing	
	FY 2006: 25 countries	FY 2006: 3/2007	
	FY 2005: 25 countries	FY 2005: 3/2006	
	FY 2004: 25 countries	FY 2004: 25 (Met)	
	FY 2003: 25 countries	FY 2003: 20 (Unmet)	
	FY 2002: 25 countries	FY 2002: 20 (Unmet)	
	Locally appropriate technical assistance for treatment of STDs, TB, and other opportunistic infections	Locally appropriate technical assistance for treatment of STDs, TB, and other opportunistic infections	
	FY 2006: 25 countries	FY 2006: 3/2007	
	FY 2005: 25 countries	FY 2005: 3/2006	
FY 2004: 25 countries	FY 2004: 23 (Unmet)		
FY 2003: 25 countries	FY 2003: 20 (Unmet)		
FY 2002: 25 countries	FY 2002: 20 (Unmet)		

Goal 1, Performance Measure 1:

Surveillance: In FY 2004, CDC supported surveillance efforts in 25 countries. In FY 2005 and 2006, CDC will continue to support surveillance in all 25 GAP countries, with a particular interest in the 15 focus countries.

Voluntary Counseling and Testing: In FY 2004, CDC strengthened voluntary counseling and testing (VCT) programs in all 25 countries by providing technical assistance to ensure the quality and accuracy of HIV testing, strengthening laboratory diagnostic capabilities, identifying methods to target groups at high risk, and enhancing linkages between VCT and health and social services. CDC will continue to support VCT in 25 countries in FY 2005 and 2006.

Locally Appropriate Technical Assistance for Treatment of STDs, TB, and Other Opportunistic Infections: In FY 2004, CDC worked to initiate, expand or strengthen locally appropriate technical assistance for treatment of sexually transmitted infections (STIs), TB, and other AIDS-related diseases in 23 countries. CDC will work to support technical assistance for STDs, TB and other opportunistic diseases in 25 countries in FY 2005 and 2006. In FY 2004, work plans changed for two countries and these countries reprioritized their activities based on input from the in-country Ministry of Health, other government officials, and other in-country partners.

Performance reporting dates for FY 2005 and 2006 have been changed to reflect the new reporting period.

GOAL 2: COUNSEL, TEST, AND TREAT UP TO 1 MILLION PREGNANT WOMEN AND REDUCE MOTHER TO CHILD TRANSMISSION BY UP TO 40% AMONG WOMEN TREATED, BY WORKING WITH USAID.

Performance Measure	Targets	Actual Performance	Ref
1. Increase the number of countries participating in the President's International Mother and Child HIV Prevention Initiative that have coordinated needs assessments, planned programs, and begun implementation.	Coordinated needs assessments FY 2004: 14 countries	Coordinated needs assessments FY 2004: 14 (Met) FY 2002: 0 countries (Baseline)	
	Planned programs FY 2004: 14 countries	Planned programs FY 2004: 14 (Met) FY 2002: 0 countries (Baseline)	
FY 00-03: Initiate, expand, or strengthen perinatal HIV prevention programs in collaboration with national and international partners.*	Begun implementation FY 2004: 14 countries FY 2003: 20 countries FY 2002: 17 countries	Begun implementation FY 2004: 14 (Met) FY 2003: 20 (Met) FY 2002: 0 countries (Baseline)	

* Funds for the President's International Mother and Child HIV Prevention Initiative and the President's Emergency Plan for AIDS Relief will be included in the FY 2005 budget request of the Department of State. CDC will cease to report on this measure after FY 2004.

Goal 2, Performance Measure 1:

These efforts are being incorporated into the President's Emergency Plan for AIDS Relief (Emergency Plan) and in FY 2005, funding used to support this initiative will be included in the Department of State's budget request. In FY 2004, CDC provided Prevention of Mother-to-Child Transmission of HIV (PMTCT) services in 22 countries. This includes programs in both focus and non-focus countries. For FY 2004, the target was set for only countries participating in the PMTCT initiative. With this change, CDC will no longer report on this measure, and it will be retired after data are reported for FY 2004.

GLOBAL IMMUNIZATION PROGRAM

GOAL 3: HELP DOMESTIC AND INTERNATIONAL PARTNERS ACHIEVE WORLD HEALTH ORGANIZATION'S GOAL OF GLOBAL POLIO ERADICATION.

Performance Measure	Targets	Actual Performance	Ref
1. Purchase doses of oral polio vaccine for mass immunization campaigns in Asia, Africa, and Europe.	FY 2006: 500 million doses FY 2005: 500 million doses FY 2004: 500 million doses FY 2003: 600 million doses	FY 2006: 6/2007 FY 2005: 6/2006 FY 2004: 500 million doses (Met) FY 2003: 550 million doses (Unmet)	HHS-1
2. Achieve and sustain zero cases of polio by 2005. [O]	FY 2006: 0 FY 2005: 0 FY 2004: 100 FY 2003: 200 FY 2002: 500	FY 2006: 12/2007 FY 2005: 12/2006 FY 2004: 12/2005 FY 2003: 784 (Unmet) FY 2002: 1,918 (Unmet)	HHS-1, PART

UNICEF provides the number of doses of polio purchased with CDC funding via an annual report that is part of the CDC/WHO cooperative agreement. WHO provides the polio case data based on reports submitted by countries.

Goal 3, Performance Measure 1:

In FY 2004, CDC purchased 500 million doses of polio vaccine for use in mass global immunization campaigns. As planned, CDC purchased slightly less polio vaccine doses in FY 2004 compared to FY 2003, allowing CDC to place greater emphasis on surveillance and operational costs in all endemic and high risk countries. This performance measure corresponds with the 1999 resolution of the World Health Assembly of the WHO.

Goal 3, Performance Measure 2:

Global polio incidence has declined by more than 99 percent from about 350,000 cases in 1988 to 784 cases in 2003. About 250,000 lives have been saved, four million cases of childhood paralysis have been avoided, and the number of polio-endemic countries has dropped from 125 in 1988 to six in 2003.

In 2004, the American Region of WHO completed its thirteenth year without a reported case of polio due to the wild virus. The Western Pacific Region (includes China, Vietnam, and Cambodia among its 35 countries) and the European Region (51 countries) have achieved regional eradication of polio. However, a large, ongoing polio outbreak in northern Nigeria is likely to postpone the achievement of polio eradication until 2006 and has resulted in outbreaks of polio in previously polio-free countries across west and central Africa. As long as polio transmission occurs anywhere in the world, it remains a threat to American children. CDC will continue to fight against polio by collaborating with partners to increase the number and quality of National Immunization Days, as well as intensify implementation of the other strategies to interrupt transmission in the remaining six endemic countries. CDC will continue to provide scientific assistance to improve tracking to certify that polio eradication has occurred.

GOAL 4: WORK WITH GLOBAL PARTNERS TO REDUCE THE CUMULATIVE GLOBAL MEASLES-RELATED MORTALITY RATE.			
Performance Measure	Targets	Actual Performance	Ref
1. By 2005, reduce by 50% the cumulative global measles-related mortality compared with 1999 estimates (Baseline: 875,000 deaths). [O]	FY 2006: 435,000 FY 2005: 435,000 FY 2004: 500,000 FY 2003: 621,600	FY 2006: 6/2008 FY 2005: 6/2007 FY 2004: 6/2005 FY 2003: 530,000 (Exceeded) FY 2002: 644,000 FY 2001: 745,000 FY 2000: 777,000	HHS-1
2. Eliminate measles transmission in all 47 countries of the Americas. [O]	FY 2006: less than 500 cases FY 2005: less than 500 cases FY 2004: less than 500 cases FY 2003: less than 500 cases	FY 2006: 6/2007 FY 2005: 6/2006 FY 2004: 6/2005 FY 2003: 119 (47/47 countries) (Exceeded) FY 2002: 2,588 cases (45/47 countries)	HHS-1

Goal 4, Performance Measure 1:

Based on previous success with nationwide measles immunization campaigns, CDC reviewed immunization programs in Bangladesh, China, Nicaragua, Paraguay, and the Ukraine, and provided technical support for measles surveillance or campaigns in 25 countries in 2004. CDC bought measles vaccines for campaigns in 21 countries. In addition, CDC provided technical assistance to respond to measles outbreaks in China, Cote d'Ivoire, Dominican Republic, Fiji, and southern Sudan, resulting in the curtailment of the outbreak in all of these countries. Measles has been eliminated from the Western Hemisphere. Measles mortality in the African region has been reduced by 49 percent since 1999.

Goal 4, Performance Measure 2:

The FY 2003 target has been exceeded. In 2003, there were only 119 cases of measles among the reporting countries of the Americas. According to available surveillance information, measles transmission has been interrupted in all countries of the Western Hemisphere since November 2002. However, imported measles cases, with limited secondary spread, continue to occur in several countries, including the U.S. Deaths from measles complications in the Americas have virtually disappeared. Globally, measles caused an estimated 530,000 deaths in 2003 and was the leading cause of death among children under five years of age from a vaccine-preventable disease. This performance measure corresponds with the goal adopted by the Pan American Health Organization (PAHO).

PUBLIC HEALTH IMPROVEMENT AND LEADERSHIP

LEADERSHIP AND MANAGEMENT

OFFICE OF HEALTH EQUITY

GOAL 1: PREPARE MINORITY MEDICAL, VETERINARY, PHARMACY, AND GRADUATE STUDENTS FOR CAREERS IN PUBLIC HEALTH.

Performance Measure	Targets	Actual Performance	Ref
1. Increase the number of minority students participating in the Hispanic Health Professions Internship Program, Ferguson Emerging Infectious Disease Fellowship Program, Public Health Summer Fellowship Program, and Project IMHOTEP.	FY 2006: 100 FY 2005: 95 FY 2004: 92 FY 2003: 65	FY 2006: 8/2006 FY 2005: 8/2005 FY 2004: 95 (Exceeded) FY 2003: 74 (Exceeded)	

Goal 1, Performance Measure 1:

CDC surpassed the FY 2004 target to enroll 92 students (by three) in four summer training programs designed to encourage minority students to pursue graduate careers in public health and to diversify the public health workforce. Demographic data are compiled for all student training programs annually.

GOAL 2: SUPPORT HBCUs, HISPANIC SERVING INSTITUTIONS, AND TRIBAL COLLEGES AND INSTITUTIONS.

Performance Measure	Targets	Actual Performance	Ref
1. Increase the number of funding mechanisms and the number of minority-serving institutions receiving support.	FY 2006: 4 cooperative agreements; 80 schools FY 2005: 5 cooperative agreements; 75 schools FY 2004: 4 cooperative agreements; 69 schools FY 2003: 4 cooperative agreements; 67 schools	FY 2006: 8/2006 FY 2005: 8/2005 FY 2004: 4 cooperative agreements (Met); 70 schools (Exceeded) FY 2003: 4 cooperative agreements (Met); 70 schools (Exceeded)	

Goal 2, Performance Measure 1:

The FY 2004 performance goal to support Historically Black Colleges and Universities (HBCUs), Hispanic Serving Institutions, and Tribal Colleges and Institutions was achieved through the award of cooperative agreements. In FY 2004, a total of 70 schools were reached through four cooperative agreements, exceeding the 2004 target by one school. CDC has continued to strengthen its efforts to expand and diversify partnerships with academic institutions and to increase the competence and diversity of the public health workforce.

GOAL 3: FOSTER A STRONGER COLLECTIVE DEPARTMENTAL PERSPECTIVE ON AI/AN ISSUES.			
Performance Measure	Targets	Actual Performance	Ref
1. Working in conjunction with IHS, identify and pursue areas of mutual interest and benefit.	<p>FY 2006: 1 Senior Policy Workgroup meeting; 6 CDC –IHS intra-agency agreements; Matriculate 1 IHS-sponsored EIS recruit; train 60 IHS/tribal-based providers in cervical and colorectal cancer screening techniques; improved estimates of national AI/AN cancer incidence rates.</p> <p>FY 2005: 1 Senior Policy Workgroup meeting; 6 CDC-IHS intra-agency agreements; 1 new CDC-IHS EIS training agreement; 1 IHS national immunization data validation report; train 50 IHS/tribal-based providers in cervical and colorectal cancer screening techniques; correct AI/AN racial misclassification in 30 state cancer registries.</p> <p>FY 2004: Implement 6-point Senior Policy Workgroup workplan; establish new CDC AI/AN budget analysis procedures; 1 new CDC – IHS intra-agency agreement with HIS.</p>	<p>FY 2006: 10/2006</p> <p>FY 2005: 10/2005</p> <p>FY 2004: Began implementation of workplan and establishment of procedures (Met); Implemented 6 IAA with IHS (Exceeded)</p>	HHS-3

Goal 3, Performance Measure 1:

In FY 2004, the CDC/ATSDR Indian Health Service (IHS) Senior Policy Workgroup finalized and initiated stepwise implementation of the proposed six-point workplan. The agencies will continue to implement new procedures to more accurately measure and monitor programmatic resources that target American Indian/Alaska Native (AI/AN) populations and communities, to establish an inventory of AI/AN-focused programs, and to improve AI/AN access to CDC/ATSDR programs. In addition, CDC implemented six intra-agency agreements (IAA) with IHS that address cancer, diabetes, heart disease, injuries, smoking, immunizations, sexually transmitted diseases, and viral hepatitis. CDC also initiated a new IAA addressing reproductive health issues.

PUBLIC HEALTH WORKFORCE DEVELOPMENT

EFFICIENCY MEASURE	TARGETS	ACTUAL PERFORMANCE	REF.
1. By 2006, increase the efficiency with which the OMB Clearance package for Epi-Aids is processed, resulting in reduced number of staff hours spent in preparing the package for submission. [E]	<p>FY 2006: 50 hours</p> <p>FY 2005: 50 hours</p>	<p>FY 2006: 12/2007</p> <p>FY 2005: 12/2006</p> <p>FY 2004: 12/2005</p> <p>FY 2003: 200 hours (Baseline)</p>	HHS-8, HP-23

Efficiency Measure 1:

This measure focuses on increasing the efficiency with which the OMB Clearance package for Epi-Aids is processed. It will result in reduced number of staff-hours in preparing the package for submission and tracking the results of Epi-Aids. It is anticipated that staff hours will be reduced from 200 in FY 2003 to 50 hours in FY 2005 and 2006.

GOAL 1: BY 2006, CDC WILL DEVELOP AND IMPLEMENT TRAINING TO PROVIDE FOR AN EFFECTIVE, PREPARED, AND SUSTAINABLE HEALTH WORKFORCE ABLE TO MEET EMERGING HEALTH CHALLENGES. *

Performance Measure	Targets	Actual Performance	Ref
1. Number of EIS officers assigned to state or municipal health departments.	FY 2005: 50 FY 2004: 48 FY 2003: 49	FY 2005: 07/2005 FY 2004: 48 (Met) FY 2003: 49 (Met)	HHS-8, HP-23
2. Increase the number of local, state, and federal healthcare professionals who participate in training in epidemiology, lab or public health leadership management.	FY 2006: 300 FY 2005: 300 FY 2004: 200	FY 2006: 12/2007 FY 2005: 12/2006 FY 2004: 12/2005	HHS-2, 4, HP-23

* This goal has been revised to more accurately reflect the goals and activities that are envisioned as a priority focus at CDC, with an emphasis on life long learning for CDC's workforce and external partners (e.g. state and local health workforce). This goal is consistent with the Futures Initiative.

Goal 1, Performance Measure 1:

In achievement of CDC's performance target, 48 Epidemic Intelligence Service (EIS) officers were placed in field assignments in 2004. These placements provide cross-cutting experiences in many subject areas, such as infectious disease, environmental health, injury prevention, maternal/child health, and chronic disease prevention/health promotion. EIS Field officers experience a high degree of autonomy and responsibility as vital members of their health department teams. They have the opportunity to take the lead in investigations in their state, to interact with the public, and to produce top-quality scientific presentations and papers. According to Former Secretary Tommy Thompson, "every state should have at least one federally funded epidemiologist who has been trained in the CDC's Epidemic Intelligence Service training program." This measure will be retired after data are reported for FY 2005.

Goal 1, Performance Measure 2:

In response to an August 2003 report that identified capacities and gaps at the state and local levels, training methodologies are being developed on epidemiology for both entry-level and experienced participants as needed. CDC has worked to build cross-agency partnerships and form collaborations with Council of State and Territorial Epidemiologists (CSTE), The Association of State and Territorial Health Officials (ASTHO) and The National Association of County and City Health Officials (NACCHO). CDC has explored partnerships with academic institutions and other organizations such as The National Environmental Health Association (NEHA) and the Association of State and Territorial Directors of Nursing (ASTDN). Efforts to address these gaps will be made by designing and offering training and continuing education in basic epidemiology and outbreak investigation, for local front-line workers already working in public health. Additionally, an effort to identify and validate competencies in epidemiology has been initiated.

This measure has been revised to more accurately reflect the goals and activities that are envisioned as a priority focus at CDC, with an emphasis on life long learning for CDC's workforce and external partners (e.g. state and local health workforce). This measure is consistent with the Futures Initiative.

GOAL 2: INCREASE THE NUMBER OF FRONTLINE PUBLIC HEALTH WORKERS AT THE STATE AND LOCAL LEVEL THAT ARE COMPETENT AND PREPARED TO RESPOND TO BIOTERRORISM, INFECTIOUS DISEASE OUTBREAKS, AND OTHER PUBLIC HEALTH THREATS AND EMERGENCIES; AND PREPARE FRONTLINE STATE AND LOCAL HEALTH DEPARTMENTS AND LABORATORIES TO RESPOND TO CURRENT AND EMERGING PUBLIC HEALTH THREATS.

Performance Measure	Targets	Actual Performance	Ref
1. Evaluate the impact of training programs conducted by the NLTN on laboratory practices.	FY 2006: 90% of the public health and clinical laboratorians attending NLTN courses can correctly handle, process, or identify potential disease agents.	FY 2006: 11/2006	HHS-2, 4, 5, HP-23

GOAL 2: INCREASE THE NUMBER OF FRONTLINE PUBLIC HEALTH WORKERS AT THE STATE AND LOCAL LEVEL THAT ARE COMPETENT AND PREPARED TO RESPOND TO BIOTERRORISM, INFECTIOUS DISEASE OUTBREAKS, AND OTHER PUBLIC HEALTH THREATS AND EMERGENCIES; AND PREPARE FRONTLINE STATE AND LOCAL HEALTH DEPARTMENTS AND LABORATORIES TO RESPOND TO CURRENT AND EMERGING PUBLIC HEALTH THREATS.

Performance Measure	Targets	Actual Performance	Ref
	<p>FY 2005: Reduce rejection rates of specimens submitted to state laboratories for newborn screening as a result of training.</p> <p>FY 2004: Assess the increase in the number of laboratories that adopt specific NCCLS practices for antimicrobial susceptibility testing and reporting.</p>	<p>FY 2005: 8/2005</p> <p>FY 2004: 34% increase (Baseline)</p>	

Goal 2, Performance Measure 1:

During FY 2004, National Laboratory Training Network (NLTN) conducted 225 training courses and trained 20,666 participants through cost-effective, high quality continuing education in the laboratory sciences. NLTN courses are available in a variety of formats and are developed based on documented training needs and delivered in collaboration with state public health laboratories. Course topics include bioterrorism (BT) and chemical terrorism (CT) preparedness, safe packaging and shipping of diagnostic and infectious agents, antimicrobial susceptibility testing (AST), and newborn screening. Selected courses from the previous year are evaluated to determine outcomes of training.

A report on the effectiveness of the NLTN courses in promoting the adoption of the Clinical and Laboratory Standards Institute (formerly National Committee for Clinical Laboratory Standards) AST standards was completed in October 2004. Use of the NCCLS standards is voluntary, but laboratories that adopt the standards are more likely to produce more accurate testing results.

In 2005, NLTN will conduct training nationwide on the proper collection of bloodspot specimens for newborn screening and evaluate changes in specimen rejection rates as a result of the training.

PREVENTIVE HEALTH & HEALTH SERVICES BLOCK GRANT

EFFICIENCY GOAL: PROVIDE DYNAMIC SUPPORT FOR HIGH-PRIORITY STATE AND LOCAL DISEASE PREVENTION AND HEALTH PROMOTION PROGRAMS.

Performance Measure	Targets	Actual Performance	Ref
1. Eliminate the hours it takes to install GARS software on grantees machines by establishing a Web-based system.	FY 2005: 0 hours	FY 2005: 12/2006 FY 2004: GARS becomes web-based 12/2005	HHS-8

Efficiency Measure 1:

A non web-based GARS is burdensome and inefficient for states and CDC. This burden is exacerbated as states face deep budget cuts. State health departments will save 1,952 hours per year on project reporting by using a Web-based GARS (1,952 grantee hours = average of four system per grantee X 61 grantees X eight hours per installation). CDC will save 720 hours, for a total saving of 2,672 hours.

The Preventive Health and Health Services Block Grant program is being eliminated for FY 2006.

BUILDINGS AND FACILITIES

EFFICIENCY MEASURE	TARGETS	ACTUAL PERFORMANCE	REF.
1. Energy and water reduction. [E]	FY 2006: Energy 20%; Water 30% FY 2005: Energy 20%; Water 15%	FY 2006: 12/2006 FY 2005: 12/2005 FY 2003: Energy 8% reduction; Water 19% reduction (Baseline)	PART
2. Deliver leased space below Atlanta's sub-market rate. [E]	FY 2006: 0% under market FY 2005: 10% under market	FY 2006: 10/2006 FY 2005: 10/2005 FY 2003: 5% under market (Baseline)	PART

Efficiency Measure 1:

In response to Executive Order #13123 identifying specific energy reduction goals and applying water management strategies, CDC has initiated monitoring and strategic planning efforts to ensure full compliance with the Executive Order and internal water management standards.

Efficiency Measure 2:

To demonstrate the most efficient use of taxpayer dollars, this measure will monitor leased space cost with the expectation of delivering quality space below sub-market rates.

GOAL 1: IMPLEMENT SCHEDULED IMPROVEMENTS, CONSTRUCTION, SECURITY, AND MAINTENANCE CONSISTENT WITH AVAILABLE RESOURCES AND PRIORITIES IDENTIFIED IN CDC'S MASTER FACILITIES PLANNING PROCESS.			
Performance Measure	Targets	Actual Performance	Ref
1. Aggregate of scores for capital projects rated on scope, schedule, budget, and quality. <i>Design starts FY 2004.</i>	FY 2006: Greater than or equal to 90% FY 2005: Greater than or equal to 90% <u>Roybal Campus</u> East Campus Consolidated Lab Project, Bldg 23 FY 2004: Begin design Epi Tower, Bldg 24 FY 2004: Begin design <u>Chamblee Campus</u> Environmental Health Facility, Bldg 106 FY 2004: Design target adjusted to FY 2005 <u>Cincinnati Campus</u> Lab Consolidation – Site Acquisition FY 2004: Conduct site analyses <u>Roybal Campus</u> HQ & Emergency Ops Center, Bldg 21 FY 2004: Begin construction	FY 2006: 10/2006 FY 2005: 10/2005 <u>Roybal Campus</u> East Campus Consolidated Lab Project, Bldg 23 FY 2004: Met Epi Tower, Bldg 24 FY 2004: Unmet (Pending Funding Authority Approval) <u>Chamblee Campus</u> Environmental Health Facility, Bldg 106 FY 2004: 3/2005 <u>Cincinnati Campus</u> Lab Consolidation – Site Acquisition FY 2004: Met <u>Roybal Campus</u> HQ & Emergency Ops Center, Bldg 21 FY 2004: Met	PART
<i>Construct CDC buildings FY 2004.</i>			

GOAL 1: IMPLEMENT SCHEDULED IMPROVEMENTS, CONSTRUCTION, SECURITY, AND MAINTENANCE CONSISTENT WITH AVAILABLE RESOURCES AND PRIORITIES IDENTIFIED IN CDC'S MASTER FACILITIES PLANNING PROCESS.			
Performance Measure	Targets	Actual Performance	Ref
	Infrastructure and security upgrades, Bldg 20 FY 2004: Continue construction FY2003: Begin Construction Scientific Communications Center, Bldg 19 FY 2004: Continue construction FY 2003: Begin construction Emerging Infectious Disease Lab, Bldg 18 FY 2004: Continue construction FY 2003: Continue construction <u>Chamblee Campus</u> Environmental Toxicology Lab, Bldg 110 FY 2004: Continue construction FY 2003: Continue construction <u>Ft. Collins, CO Campus</u> FY 2004: Complete design; begin construction FY 2003: Begin design	Infrastructure and security upgrades, Bldg 20 FY 2004: Met FY2003: Met Scientific Communications Center, Bldg 19 FY 2004: Met FY 2003: Met Emerging Infectious Disease Lab, Bldg 18 FY 2004: Met FY 2003: Met <u>Chamblee Campus</u> Environmental Toxicology Lab, Bldg 110 FY 2004: Met FY2003: Met <u>Ft. Collins, CO Campus</u> FY 2004: Met FY 2003: Met	
2. Placement of NCID & NCEH laboratorians in CDC standard space (Projects occupied or underway).	FY 2006: NCID 70%; NCEH 100% FY 2005: NCID 70%, NCEH 100%	FY 2006: 10/2006 FY 2005: 10/2005	PART
3. Relationship of work orders (scheduled and unscheduled maintenance).	FY 2006: Scheduled 95%; Unscheduled 5% FY 2005: Scheduled 95%, Unscheduled 5%	FY 2006: 10/2006 FY 2005: 10/2005	PART

Goal 1, Performance Measure 1:

The aggregate scoring of four vital components (scope, schedule, cost and quality) of capital construction will most accurately assess successful performance and use of appropriated funds. The four combined components provide a comprehensive snapshot of capital construction. Scope, schedule, cost and quality are identified and approved consistent with the Facilities Project Approval Agreement process. The scope component will identify the predefined project needs; the schedule component will reflect the critical milestone dates; the cost component will establish the approved project budget; and the quality component will incorporate the scoring reflecting the use of appropriate building standards and codes.

This measure was modified for the Buildings and Facilities PART review during the FY 2006 budget cycle, and consolidates two former GPRA measures. The measure has been updated to reflect this change.

- **Design starts** – In FY 2004, CDC and HHS decided to utilize the Design-Build approach with the Environmental Health Facility, Building 106 project. The revised FY 2005 target date was the result of implementing the Design Build approach.
- **Construct CDC buildings** – Following September 11, 2001, the design of the Environmental Toxicology Lab (Building 110) was the subject of a required security assessment. The FY 2004 target date was adjusted to FY 2005 to incorporate the security upgrades required as a result of this assessment.

Goal 1, Performance Measure 2.

The movement of CDC laboratorians into CDC standard space will facilitate CDC's ability to meet its scientific mission. CDC standard space includes standards for bio-safety, CDC design, space planning, and accreditation of laboratory animal care and HHS utilization rate policy. This metric has underlying assumptions concerning the stability of CDC's growth rates, workforce composition, laboratory standards, and applicable codes. Any significant changes in baseline assumptions would require appropriate upward/downward adjustments to target rates.

Goal 1, Performance Measure 3:

This measure will track the percentage of maintenance projects that are scheduled (i.e., planned) to maintain the facilities, versus the percentage of unscheduled work orders tied to repairs of non-functioning or faulty systems. In general, all facilities are better protected through scheduled maintenance.

TERRORISM



EFFICIENCY GOAL: CREATE PROGRAM EFFICIENCIES THAT IMPROVE SERVICES AND CONSERVE R MISSION-CRITICAL ACTIVITIES.			
Performance Measure	Targets	Actual Performance	Ref
1. Fully automate the application, workplan and semi-annual reporting for cooperative agreement grantees to achieve greater program efficiencies.	FY 2006: All grantees using system FY 2005: 62 grantees using system	FY 2006: 12/2006 FY 2005: 12/2005 FY 2003: 57 grantees using the system, with limited functionality (Baseline)	HHS-8, -3, 4


Efficiency Measure 1:

In FY 2003, the cooperative agreement program initiated development of a system to automate the application process for grantees. Grantees were able to supply their grant applications in FY 2004 for review in a secure, electronic format. Benefits of the system and new supporting processes are expected to improve timeliness of applications, ease of processing and production for review as well as elimination of paper processing. Additionally, development of the system addresses e-government provisions of the President's Management Agenda.

DETECTION

GOAL 1: RAPIDLY DETECT PUBLIC HEALTH EMERGENCIES INVOLVING CBRN AGENTS.			
Performance Measure	Targets	Actual Performance	Ref
1. 100% of state and local public health agencies will be in compliance with CDC recommendations for using standards-based, electronic disease surveillance systems for appropriate routine public health information collection, analysis and reporting appropriate public health authorities.	FY 2006: 100% FY 2005: 100%	FY 2006: 12/2006 FY 2005: 12/2005	HHS-5, -4, PART
2. Increase the number of state and major city health departments and other sentinel sites with expanded epidemiology and surveillance capacity to detect, investigate, and mitigate health threats by bioterrorism.	FY 2004: Maintain 62 sites	FY 2004: 62 (Met)	HHS-2
3. Support terrorism preparedness and emergency response training for EIS officers and CEFOs assigned to state and local public health departments.	FY 2006: 67 FY 2005: 67 FY 2004: 48 FY 2003: 41	FY 2006: 2/2006 FY 2005: 2/2005 FY 2004: 67 (Exceeded) FY 2003: 41 (Met)	HHS-2
4. Increase the number of state and local public health professionals who use Epi-X to share intelligence regarding outbreaks and other emerging health events including those suggestive of bioterrorism.	FY 2006: 3,200 FY 2005: 3,000 FY 2004: 2,100	FY 2006: 12/2006 FY 2005: 12/2005 FY 2004: 2,812 (Exceeded)	HHS-2, 5, -4
5. Increase the number of reports of disease outbreaks and other emerging health events posted on Epi-X annually.	FY 2006: 1,400 FY 2005: 1,350 FY 2004: 1,200	FY 2006: 12/2006 FY 2005: 12/2005 FY 2004: 1,333 (Exceeded)	HHS-2, 5, -4

GOAL 1: RAPIDLY DETECT PUBLIC HEALTH EMERGENCIES INVOLVING CBRN AGENTS.			
Performance Measure	Targets	Actual Performance	Ref
6. Increase the number of states and major metropolitan areas with access to Epi-X.	FY 2006: 150 FY 2005: 125 FY 2004: 100	FY 2006: 12/2006 FY 2005: 12/2005 FY 2004: 100 (Met)	HHS-2, 5,  4
7. Percentage of Laboratory Response Network labs that pass proficiency testing for Category A and B threat agents.	FY 2006: 80% FY 2005: 75%	FY 2006: 12/2006 FY 2005: 12/2005	HHS-2, PART
8. 100% of LRN labs will report routine public health testing results through standards-based electronic disease surveillance systems and have protocols for immediate reporting by telephone for Category A agents (bacillus anthracis, yersina pestis, francisella tularensis, clostridium botulinum toxin and variola major) for which they conduct testing. [O]	FY 2006: 100% FY 2005: 100%	FY 2006: 12/2006 FY 2005: 12/2005	 4, PART
9. Increase the number of labs in LRN.	FY 2005: 160 labs FY 2004: 145 labs	FY 2005: 12/2005 FY 2004: 134 (Unmet)	HHS-2
10. Increase the capacity of state and major city labs to provide or gain access to rapid testing for potential bioterrorism agents. [O]	FY 2004: 100 labs	FY 2004: 116 (Exceeded)	HHS-2
11. Increase the number of rapid diagnostic tests to be developed for potential bioterrorism agents.	FY 2004: 20 tests	FY 2004: 51 (Exceeded)	HHS-2
12. 100% of states will have level 1 chemical lab capacity, and have agreements with and access to (specimens arriving within 8 hours) a level-three chemical lab equipped to detect exposure to nerve agents, mycotoxins, and select industrial toxins.	FY 2006: 100% FY 2005: 25%	FY 2006: 12/2006 FY 2005: 12/2005	HHS-2, PART
13. Increase the number of labs qualified to provide surge capacity for analysis of chemical agents.	FY 2006: 10 labs FY 2005: 8 labs FY 2004: 5 labs	FY 2006: 12/2006 FY 2005: 12/2005 FY 2004: 5 (Met)	HHS-2
14. Maintain at 150 the number of toxic substances likely to be used in chemical terrorism that can be rapidly measured in blood and urine.	FY 2006: 150 substances FY 2005: 150 substances FY 2004: 150 substances	FY 2006: 12/2006 FY 2005: 12/2005 FY 2004: 150 (Met)	HHS-2
15. Enhance lab capacity for testing and submission of biological agents that could be used in identification is available for all U.S. jurisdictions. [O]	FY 2004: 100% of state labs will have the ability to accept, package, and submit for transport all Category A and B biological agents; test for agents on the Category A list, and refer hemorrhagic fever agents to CDC for analysis	FY 2004: 100% (Met)	HHS-2

GOAL 1: RAPIDLY DETECT PUBLIC HEALTH EMERGENCIES INVOLVING CBRN AGENTS.			
Performance Measure	Targets	Actual Performance	Ref
<p>16. Evaluate the impact on the performance/preparedness of frontline public health workforce resulting from education and training programs implemented or supported by CDC, including CPHP system.</p>	<p>FY 2006:</p> <p>a) 10% of local health departments (LHDs) achieve certification under "Project Public Health Ready" (denominator: 3,000 LHDs)</p> <p>b) 90% of the 50 State Distance Learning Coordinators (DLCs) receive basic competency training.</p> <p>FY 2005:</p> <p>a) Evaluate impact of programs in 50% of states</p> <p>b) 90% of LHD participants in Phase II of "Project Public Health Ready" achieve certification (denominator = 25 LHDs)</p> <p>c) Implement and evaluate "Project Public Health Ready" in 3 statewide programs.</p> <p>d) 90% of states are served by a CPHP.</p> <p>e) 40% of LHDs deploy distributed learning technology in public health education and training (denominator: 3,000 LHDs)</p> <p>f) 85% of the 50 State DLCs receive basic competency training</p> <p>FY 2004:</p> <p>a) Evaluate impact in 30% of states</p> <p>b) 10% of LHDs achieve certification under "Project Public Health Ready" (denominator: 13 pilot sites)</p> <p>c) 80% of states served by a CPHP</p> <p>d) 50% of LHDs deploy distributed learning technology in public health education and training (denominator: 3,000 LHDs)</p> <p>e) 50% of the 50 current Distance Learning Coordinators have initiated basic competency training.</p> <p>FY 2003:</p> <p>a) Initiate evaluation in 10% of states</p> <p>b) Begin demonstration phase of "Project Public Health Ready"</p> <p>c) 50% of states served by CPHP</p> <p>d) 30% of LHDs deploy distributed learning technology in public health education and training</p> <p>e) 10% increase in DLCs trained in basic core competencies</p>	<p>FY 2006:</p> <p>a) 5/2006</p> <p>b) 12/2006</p> <p>FY 2005:</p> <p>a) 12/2005</p> <p>b) 5/2005</p> <p>c) 5/2005</p> <p>d) 10/2005</p> <p>e) 12/2005</p> <p>f) 12/2005</p> <p>FY 2004:</p> <p>a) 30% (Met)</p> <p>b) 85% (11 out of 13 pilot test sites) (Met)</p> <p>c) 92% (Exceeded)</p> <p>d) 50% (Met)</p> <p>e) 88% (Exceeded)</p> <p>FY 2003:</p> <p>a) Evaluation framework adapted (Met)</p> <p>b) 12 pilot sites selected (Met)</p> <p>c) 82% (Exceeded)</p> <p>d) 30% (Met)</p> <p>e) 84% of DLCs completed basic courses for core competencies (Met) (Baseline: 0 DLCs)</p>	<p>HHS-2, 4, 5, -5</p>

Goal 1, Performance Measure 1:

CDC is making significant progress in meeting this measure. As a result of federal funding and guidance most jurisdictions now report using disease surveillance systems. The first report of performance related to this measure will occur in December 2005.

Goal 1, Performance Measure 2:

Epidemiology and surveillance capacity to detect, investigate, and mitigate public health threats are determined by the ability to:

- Detect a terrorist event through a highly functioning, mandatory reportable disease surveillance system.
- Investigate and respond to an event as evidenced by a comprehensive and exercised epidemiologic response plan.
- Investigate and respond to a potential event as evidenced by ongoing state and local response to naturally occurring public health events.

CDC is making significant progress regarding this measure to help make sure that state and major city health departments have this added capacity. This measure will be retired after data are reported for FY 2004.

Goal 1, Performance Measure 3:

Currently, CDC maintains 48 Epidemiologic Investigation Service (EIS) officers and 19 Career Epidemiology Field Officers (CEFOs) in states and local jurisdictions, with recruitment efforts that will lead to maintaining this level. CDC ensures they have the knowledge, skills, and tools to respond to terrorism preparedness and emergency response needs through training in areas such as, but not limited to, team leadership, forensic epidemiology, field exercises, incident command structures, legal issues, and agent-specific strategies.

Goal 1, Performance Measures 4 – 6:

Measures 4 – 6 relate to Epi-X, CDC's secure Web-based communications network for public health officials, which links HHS and CDC with state terrorism surveillance and response programs, provides emergency alerts, and creates a forum to share important disease information nationwide. CDC is making continual progress regarding these measures, by increasing the number of public health professionals who use Epi-X with a push toward 3,200 total users by FY 2006 (measure 4), by posting more reports of disease outbreaks up to a projected total of 1,400 in FY 2006 (measure 5), and continuing to add local jurisdictions into the Epi-X network to a goal of 150 jurisdictions in FY 2006 (measure 6). For measure 6, the targeted numbers for FY 2005 and 2006 were adjusted downwardly from 200 and 150, respectively, to reflect a change in the targeted population for jurisdictions likely to have local public health officials interested in utilizing the Epi-X program.

Goal 1, Performance Measures 7 – 11:

Measures 7 – 11 relate to the Laboratory Response Network (LRN), which is a consortium of laboratories comprised primarily of state, local, and federal public health laboratories, each with different capabilities and levels of expertise.

For performance measures 7 and 8, CDC is making considerable progress regarding increasing proficiency testing and posting of health testing results. For example: 96 percent of LRN laboratories can test for *Bacillus anthracis*; 93 percent can test for *Yersinia pestis*; and 93 percent can test for *Francisella tularensis*. However, strengthening the LRN capacity in this area remains an objective for this measure along with other measures relating to the LRN. In addition to specific agents, rapid diagnostics and rapid testing of potential bioterrorism agents is important to the mission of the LRN. Speed and accuracy in analyzing a potential bioterrorist agent is key to mitigating the effects on morbidity and mortality following an attack. Measure 7 was modified to more closely align with the language and targets set during the State and Local Preparedness PART review.

For performance measure 9, CDC is continuing to expand the number of laboratories included in the LRN. Historically, 12 to 15 laboratories have been added to the LRN in each of the past four years. For FY 2004, the LRN increased by 23 laboratories, from 113 to 134. In FY 05, it is anticipated that a 5 – 10 percent increase will be achieved resulting in six to 13 laboratories being added, for a total of 140 – 147. The targeted goal for FY 2004 of 145 was not fully realized due to a thorough programmatic reexamination of the labs in the LRN that took out labs that did not meet all the LRN standards. The LRN will continue to grow from the new lower baseline. Measure 9 will be retired after data are reported for FY 2005.

For performance measure 10, the national capacity of the LRN continues to increase as reflected by its increasing number of participants and also by the deployment of sophisticated molecular assays to rapidly detect category A and B agents. This unforeseen dynamic of on-going new membership, compounded by newly introduced protocols presents an inherent challenge for measuring "capacity". For consistency and simplicity, "capacity" for this measure is defined as laboratories having the expertise to rapidly identify along with appropriate access to rapid testing methods

for *Bacillus anthracis*, *Francisella tularensis*, and *Yersinia pestis*. CDC anticipates meeting the capacity goal in FY 2004 for number of state and city labs with access to rapid testing for potential bioterrorism agents. Measure 10 will be retired after data are reported for FY 2004.

For performance measure 11, CDC anticipates reaching the goal for the number of rapid diagnostic tests developed in FY 2004. Measure 11 will be retired after data are reported for FY 2004.

Goal 1, Performance Measure 12:

Level 1 laboratories, also called sentinel laboratories, rule out the presence of agents and refer samples to reference labs through the use of specified protocols. As a public health preparedness standard, each state should have the capacity to conduct rule-out and transfer activities. CDC is training all 62 Level 1 public health chemical laboratories (i.e., chemical terrorism coordinators in these laboratories) in the proper collection and shipment of human samples following a chemical terrorism event. This training also includes an overview of chemical agents, CDC's responsibilities in responding to chemical terrorism events, a discussion of federal regulations on diagnostic packaging procedures and evidentiary-control measures, and hands-on exercises involving the packaging and shipping of human samples.

These public health chemical laboratories will then train internal partners (e.g., hospital laboratories, HAZMAT, doctors; office laboratories) in the proper collection and shipment of human samples after a chemical-terrorism event. A total of five training sessions were completed by July 2004.

Progress is being made on this measure. Actions are underway to train laboratorians/clinicians and establish agreements, but the variance in preparedness levels between states requires approaches to be tailored according to the jurisdiction, rather than establishing a single standard applicable to all jurisdictions.

Goal 1, Performance Measure 13:

CDC's Environmental Health Laboratory is working with public health laboratories in states, territories, cities, and counties to provide assistance in expanding their chemical laboratory capacity to respond to chemical terrorism incidents or other emergencies involving chemicals. With CDC funding, laboratories are or will be able to make instrument and equipment purchases, undertake training at the Environmental Health Laboratory or at sites visited by instrument manufacturers, and engage in technology transfer and proficiency testing for methods to measure chemical agents. Five laboratories are trained to detect exposure to cyanide, toxic metals, mustard agents, nerve agents, and ricin.

Goal 1, Performance Measure 14:

The Rapid Toxic Screen (RTS) is a series of tests to identify various chemical agents in human blood or urine. In a chemical terrorism event, RTS will help determine what chemical agents were used, who has been exposed, and to what extent. While CDC has achieved the intent of the measure, key to the effectiveness of the RTS is the development and validation of methods to analyze chemical agents. During 2004, scientists at CDC's Environmental Health Laboratory developed methods to analyze biomarkers of two chemical warfare agents in people: ricin and the blistering agent sulfur mustard. The analyses determined in these methods were ricinine, a chemical that accompanies ricin when it is extracted from the castor bean and that will be present in formulations that could be used by terrorists, and a very specific metabolite of sulfur mustard, known as SBMTE. Scientists at the Environmental Health Laboratory also improved existing methods for measuring metabolites of nitrogen mustard, which is also a blistering agent, and two nerve agents, tabun and VX, in urine.

Goal 1, Performance Measure 15:

CDC met the FY 2004 target for this measure: 100 percent of state laboratories have the ability to accept, package, and submit for transport all Category A and B biological agents, test for agents on the Category A list, and refer hemorrhagic fever agents to CDC for analysis. This measure will be retired after data are reported for FY 2004.

Goal 1, Performance Measure 16:

In FY 2004, Centers for Public Health Preparedness (CPHPs) began to evaluate the impact on the preparedness of frontline public health practitioners resulting from education and training programs implemented in 46 states. The CPHP network expanded to 41 Centers established in schools and colleges of medicine, nursing, veterinary medicine, pharmacy, biological sciences, public health, and university-based medical and health science centers. CPHPs are providing preparedness education and other requested services to health agencies in 46 states (92 percent).

In FY 2004, CDC continued efforts of Project Public Health Ready, to develop certification criteria for local public health readiness, requiring development of community response plans, providing competency-based education to health and public health workers, and evaluating response through exercises. 13 local health agencies received certification and the project is being expanded.

CDC will continue to train state Distance Learning Coordinators (DLC) in the competencies needed to ensure widespread availability of distance learning opportunities for public health practitioners throughout the nation. The Public Health Training Network (PHTN) provides distance learning curricula and opportunities to improve the practice of public health by frontline health and public health providers. PHTN develops and delivers classroom training, conference calls, and satellite broadcasts. PHTN also includes self-study courses, CD-ROMs, and videos. Preparedness education programs have reached 5.3 million viewers. In 2004, users of available web-based PHTN educational programs averaged 6,500 per month.

INVESTIGATION AND RESPONSE

GOAL 2: RAPIDLY INVESTIGATE AND RESPOND TO PUBLIC HEALTH EMERGENCIES INVOLVING CBRN AGENTS.			
Performance Measure	Targets	Actual Performance	Ref
1. Properly equipped public health emergency response teams will be onsite within 4 hours of notification by local public health officials, to assess the public health impact and determine the appropriate public health intervention in response to Category A agents. [O]	FY 2006: 50% FY 2005: 25% (16) of grantees	FY 2006: 12/2006 FY 2005: 12/2005	HHS-2, -1, PART
2. Increase the availability of CBRN-certified respirators for use during a CBRN event by professional firefighters. [O]	FY 2004: 10%	FY 2004: 7.2% (Unmet)	HHS-2
3. Increase the number of certification standards and user guidelines for respirators to protect emergency responders in a CBRN event.	FY 2004: 5 classes of respirators	FY 2004: 4 (Unmet)	HHS-2
4. 100% of state public health agencies improve their capacity to respond to exposure to chemicals or category A agents by annually exercising scalable plans and implementing corrective action plans to minimize any gaps identified.	FY 2006: 100% FY 2005: 25%	FY 2006: 12/2006 FY 2005: 12/2005	HHS-2, PART, PAR
5. Conduct at least one internal and one external response exercise or training for both radiological and chemical terrorist events; prepare comprehensive annexes to the CDC Emergency Response Plan for radiological and chemical terrorist attacks.	FY 2006: 2 FY 2005: 2 FY 2004: 2	FY 2006: 12/2006 FY 2005: 12/2005 FY 2004: 2 (Met)	HHS-2
6. Enhance preparedness by ensuring state, territorial, and local jurisdiction projects have written plans to respond to biological, chemical, radiological, and mass trauma hazards related to terrorism.	FY 2004: 50%	FY 2004: 100% (Exceeded)	HHS-2, PAR
7. Enhance preparedness by ensuring that projects have demonstrated proficiency in responding to threats in the four key areas of biological, chemical, radiological, and mass trauma hazards related to terrorism based on their ability to address the National Readiness Goals.	FY 2004: 30%	FY 2004: 0% (Unmet)	HHS-2, -5
8. Enhance preparedness by ensuring written plans for multi-state/multi-jurisdiction public health preparedness coordination are in place for all grantees and these plans include signed agreements between jurisdictions.	FY 2004: 40%	FY 2004: 76% (Exceeded)	HHS-2, 5, -5

GOAL 2: RAPIDLY INVESTIGATE AND RESPOND TO PUBLIC HEALTH EMERGENCIES INVOLVING CBRN AGENTS.			
Performance Measure	Targets	Actual Performance	Ref
	FY 2004: a) 60% of states and 25% of local health departments will acknowledge receipt of health alert messages within 30 minutes of delivery on a 24/7 basis b) 50% of state grantees will have communication established with identified, key stakeholders c) 50% of state grantees will have a protocol for testing and documenting send/receive capabilities d) Establish interoperable wireless redundant communication systems in 40% of state health departments	FY 2004: a – d) Unmet	

Goal 2, Performance Measure 1:

CDC expects to reach its FY 2005 target of 25 percent. Determination of proper equipment standards, and proficient use of equipment, requires testing of various products, technical reviews, development of written standards/recommendations, coordination, and communication of those standards/recommendations to equipment manufacturers. It is challenging to establish meaningful, aggressive targets because the effort is time intensive and requires extensive coordination and communication.

Goal 2, Performance Measure 2:

Data from fire departments that have purchased CBRN Self-Contained Breathing Apparatus (SCBAs) indicate that as of December 2004, at least 7.2% of all on-duty career fire fighters have CBRN respirators available or on order. Additional data from fire department surveys and a formal collaboration with the Department of Homeland Security will be available in FY 2005 and may indicate that the target has been met. Furthermore, the overall availability of CBRN-certified respirators increased in FY 2004 through the work of CDC's Occupational Safety and Health program. During FY 2004, this program increased the number of CBRN SCBA CDC-approved respirators from three to 63. In addition, the Occupational Safety and Health program approved three models of CBRN Air Purifying Respirators. Systems have been put in place to ensure that only CDC-certified respirators can be procured with federal grant funding. This measure will be retired after data are reported for FY 2004.

Goal 2, Performance Measure 3:

Development of one additional CBRN respirator standard was completed in FY 2004. The CBRN APR Retrofit Kit Standard, including approval and application procedures, was completed. The initial day for accepting applications for approval of the Retrofit Kit is targeted for April 1, 2005. Development of the CBRN Powered Air Purifying Respirator (PAPR) standard is continuing into FY 2005 because of the ongoing/extended Benchmark testing period. The Benchmark testing has been extended due to procurement delay in obtaining high flow test equipment for evaluation as potential certification test apparatus. During 2004, initial conceptual requirements were identified for Closed Circuit SCBA. The release of the standards for the CBRN PAPR and CBRN CC SCBA is anticipated during FY 2005. This measure will be retired after data are reported for FY 2004.

Goal 2, Performance Measure 4:

The FY 2005 target for this measure is that 25 percent, or 15 states/territories/grantees, will participate in an exercise designed by the CDC exercise program to test and evaluate their plans and response systems. In FY 2006, the remaining 75 percent, or 47 states/territories/grantees, will participate. Corrective action plans based on findings of the exercise must be established by the state after each exercise within 90 days of the exercise.

This measure is a significant challenge for CDC. While states have individually developed written response plans, the development of exercises to test written plans requires consideration of the variance between preparedness levels of states.

Goal 2, Performance Measure 5:

The Director's Emergency Operations Center (DEOC) conducts and supports various exercises that include nationalization of other CDC assets through exercise-related calls initiated at state and local levels. The Strategic National Stockpile (SNS) conducts monthly exercises to ensure CDC's ability to rapidly, efficiently, and effectively deploy the SNS material.

In July 2004, CDC's Environmental Health Laboratory partnered with the Wisconsin State Laboratory of Hygiene to test laboratory readiness to respond to a chemical terrorism event. During this exercise, CDC's Laboratory Response Team, which has expertise in collecting, storing, and transporting specimens, flew to Wisconsin to retrieve 40 samples to which chemical-agent metabolites previously had been added. To determine the identity of these metabolites, they were submitted to CDC's Environmental Health Laboratory and analyzed using the Rapid Toxic Screen. For this exercise, CDC scientists correctly determined that the chemicals present in the Wisconsin samples were nitrogen mustards and nerve agents. Results were sent to the Wisconsin laboratory in less than 36 hours. The exercise was highly successful and helped CDC and its partners hone their skills and ensure their readiness to respond to a chemical terrorism event.

Goal 2, Performance Measure 6:

The Continuation Guidance for Cooperative Agreement on Public Health Preparedness and Response for Bioterrorism – Budget Year Four requires that state, territorial, and local projects “develop or enhance scalable plans that support local, statewide, and regional response to incidents of bioterrorism, catastrophic infectious disease, such as pandemic influenza, other infectious disease outbreaks, and other public health threats and emergencies (Critical Benchmark #2, and Critical Capacity #3).”

CDC is making progress regarding this measure. As of November 2004, 100 percent of the state-based projects had response plans that covered at least one of the Category A biological agents, chemical agents, or radiation. Specifically, the following percentages of grantees indicated they had statewide response plans for the listed agent: 84 percent, Anthrax; 70 percent, Botulism; 74 percent, Plague; 98 percent, Smallpox; 72 percent, Tularemia; 44 percent, Nerve Agents; 48 percent, Blood Agents; 44 percent, Blister Agents, and; 70 percent, Radiation/Nuclear. This measure will be retired after data are reported for FY 2004.

Goal 2, Performance Measure 7:

CDC has developed new cooperative agreement guidance that includes outcome goals, state, territorial, and local objectives, and key performance indicators. These goals, objectives, and measures will form the basis of CDC and third-party evaluation of readiness and improve accountability in key preparedness areas. The state and local objectives were developed using lessons learned from real events, hoaxes, exercises, and, expert opinion from national, state, and local public health professionals. State and local public health agencies must coordinate to accomplish the readiness goals.

Evaluation against these goals will begin with the new cooperative agreement in Summer 2005. This measure will be retired after data are reported for FY 2004.

Goal 2, Performance Measure 8:

As of November 2004, 76 percent of states indicated that they had developed regional plans. These plans are a combination of multi-jurisdiction plans within a state and inter-state plans.

In addition, projects have made considerable progress developing mutual aid agreements with neighboring jurisdictions and developing intra-state and inter-state regional response plans. This is not a measure that is applicable to each state. The issues include special populations, border issues with Canada/Mexico, cities that overlap state boundaries and cities that provide primary healthcare services for small jurisdictions in a neighboring state. While CDC is making progress, initial progress may be slow due to variance between the preparedness level of states, and specific state issues that require tailored solutions. For this reason, progress targets are challenging to establish. This measure will be retired after data are reported for FY 2004.

Goal 2, Performance Measure 9:

As most jurisdictions have met this measure, CDC has made significant progress regarding this measure. This measure will be retired after data are reported for FY 2005.

Goal 2, Performance Measure 10:

CDC's Field Services Office initiated a policy outlining the Public Health Readiness Field Program (PHRFP) describing placement, management, training and funding of field staff positions.

An initial step was to develop the training to prepare new emergency response field staff for responsibilities in the field. Discipline specific competency-based guidelines have been established. A two week course basic training curriculum ("boot camp") is being developed for all emergency response staff. The training plan and curriculum were coordinated with CDC training goals and are being integrated into CDC's Corporate University.

Field Services has established a relationship with partners including the Association of State and Territorial Health Officials (ASTHO), the Council of State and Territorial Epidemiologists (CSTE), and state bioterrorism coordinators to assess the needs for PHRFP staff in state and local programs. In addition, Field Services has worked to help establish the Career Epidemiology Field Officer (CEFO) program. Eleven field officers have been placed in this program with another 16 pending appointment.

Goal 2, Performance Measure 11:

All clinicians with internet access are able to receive timely information and training related to terrorism preparedness and emergency response through the CDC website, www.cdc.gov. Information resources targeted specifically to clinicians have been developed covering the diagnosis, treatment, and/or referral for treatment of persons exposed to biological, radiological, chemical, or mass trauma events related to terrorism.

The CDC web-based Emergency Preparedness and Response pages are visited by over 1.4 million users per month. In a two month period in 2004 (October – November), over 40,000 users viewed clinician-specific CDC web pages (these data exclude influenza information; therefore, the actual number of clinician users is higher). In addition, emergency preparedness information updates are sent via email each week directly to 48,700 clinicians who have enrolled in the CDC Clinician Registry.

The Public Health Training Network (PHTN) provides distance learning curricula and opportunities to improve the practice of public health by frontline health and public health providers. PHTN develops and delivers classroom training, conference calls, and satellite broadcasts. PHTN also includes self-study courses, CD-ROMs, and videos. Preparedness education programs have reached 5.3 million viewers. In 2004, users of available web-based PHTN educational programs averaged 6,500 per month.

CDC provided FY 2004 funding in continue support of the Centers for Public Health Preparedness (CPHP), a national system of academic specialty centers focusing on improving the capacity of frontline public health and healthcare workers to respond to all forms of terrorism. CDC guides CPHPs to work with state and local health agencies to assess training needs, develop programs for learning, and deliver preparedness education programs through various modalities (e.g. classroom, satellite broadcast, e-learning, CD-ROM, video archive). This measure will be retired after data are reported for FY 2004.

Goal 2, Performance Measure 12:

While FY 2004 performance measures are being reported as unmet, many have actually likely been achieved; however, in the absence of accurate and effective measurement processes, CDC is unable to report on the exact status of these areas. This area is a priority for CDC's new Public Health Informatics program, which will begin implementing processes for more effective accountability for FY 2005.

Currently, three basic building blocks for routine and emergency information dissemination are being completed nationwide by HAN:

- Continuous high-speed Internet connectivity to support rapid information access.
- Broadcast capacity to support emergency communication.
- Establishment of redundant communications.

Plans for coming years include continued technical assistance and network testing to ensure timely message translation, dissemination, local response, and feedback.

CONTROL, CONTAINMENT, AND RECOVERY

GOAL 3: RAPIDLY CONTROL, CONTAIN, AND RECOVER FROM PUBLIC HEALTH EMERGENCIES INVOLVING CBRN AGENTS.			
Performance Measure	Targets	Actual Performance	Ref
1. Ensure 100% of applications for registration meet the requirements of the select agent regulations prior to issuing a certificate of registration.	FY 2006: 100% compliance FY 2005: 100% compliance	FY 2006: 12/2006 FY 2005: 12/2005	HHS-4, 5

GOAL 3: RAPIDLY CONTROL, CONTAIN, AND RECOVER FROM PUBLIC HEALTH EMERGENCIES INVOLVING CBRN AGENTS.			
Performance Measure	Targets	Actual Performance	Ref
2. Inspect entities in accordance with the Select Agent Rule.	FY 2006: 600 labs FY 2005: 525 labs FY 2004: 300 labs	FY 2006: 12/2006 FY 2005: 12/2005 FY 2004: 498 (Exceeded)	HHS-4, 5
3. 100% of state public health agencies are prepared to use materiel contained in the SNS as demonstrated by evaluation of standard functions as determined by CDC. [O]	FY 2006: 80% Certified FY 2005: 70% certified FY 2004: 60% certified	FY 2006: 12/2006 FY 2005: 12/2005 FY 2004: 72% (Exceeded)	HHS-4, 5, PART

Goal 3, Performance Measure 1:

Ensuring the safety and security of select agents and toxins by regulating entities with these materials is paramount to CDC's prevention efforts. Entities must submit registration applications that provide evidence that they can safely and securely use, transfer, and store select agents and toxins. Only after all requirements under the regulations are satisfied will consideration be given to issue a certificate of registration.

CDC exceeded its annual targets for inspection. However, many entities use, transfer and store overlap agents. Overlap agents are those that potentially threaten animal or plant health, and also public health.

A significant challenge is the requirement of concurrence by the U.S. Department of Agriculture's Animal and Plant Health Inspection Service (APHIS) before issuing a full certificate. Entities believe issuance of a certificate by a single Federal agency indicates compliance with all Federal regulations. Inspections by CDC's public health scientists do not currently include elements of either an animal or plant health inspection. The result is that a full certification cannot be issued to an entity without either an inspection by APHIS or its concurrence with CDC's inspection. In an effort to address inspection/registration challenges, CDC has established ongoing meetings with USDA to, among other activities, develop a joint inspection checklist, a shared database, and improve communication and processes to facilitate concurrence and timely issuance of full certificates of registration.

Goal 3, Performance Measure 2:

Inspections are an integral part of the Select Agent Program's regulatory activities. After registration applications are thoroughly evaluated and questions answered, an inspection team visits the entity to directly observe and confirm that all requirements are addressed. This includes reviewing safety procedures, the security plan, records for training, access, and transfers, and inventories of the entity's select agents and toxins.

As of FY 2004, CDC completed inspection of 498 laboratories, exceeding its target of 300 laboratories. Application and registration for the Select Agent Program are currently being automated to enhance program efficiency. The FY 2005 target has been increased from 500 to 525 to be more ambitious.

Goal 3, Performance Measure 3:

Within the last 24 months, all 62 Project Areas have been assessed against this performance measure. Of these, 45 have met the minimum standards for demonstrating preparedness to use SNS assets. This equates to 72 percent of all state and local Project Areas.

CDC describes 12 functions of SNS Preparedness required for the effective management and use of deployed SNS materiel. These functions are detailed in a comprehensive planning guide and video which are available to all grantees. Based on these functions, grantees are required to develop SNS Preparedness Plans detailing the performance of these functions during an emergency.

In an effort to enhance grantee SNS preparedness planning efforts, the SNS Program maintains a staff of Program Services Consultants who provide ongoing technical advice and training assistance to grantees. The Program Services Consultants also evaluate the grantee's level of preparedness to receive, distribute and dispense SNS assets. This measure is a CDC challenge. Many jurisdictions lack proper facilities to receive the 50-ton package of SNS material. However, CDC has established two Training, Education and Demonstration (TED) packages in an effort to improve the ability of states to receive, stage, store and distribute the SNS materiel.

EXHIBIT V. SUMMARY OF FULL COST

Agency for Toxic Substances and Disease Registry Performance Program Summary Table Estimated Full Cost by Program (Dollars in Millions)			
Performance Program Area	FY 2004	FY 2005	FY 2006
INFECTIOUS DISEASES	\$1,848.8	\$1,864.1	\$1,746.9
Infectious Diseases Control	\$286.7	\$292.0	\$290.3
Goal 1	\$23.4	\$23.2	\$23.0
<i>Measure 1</i>	\$10.6	\$10.8	N/A
<i>Measure 2</i>	N/A	\$0.8	\$0.8
Goal 2	\$3.5	\$3.5	\$3.5
<i>Measure 1</i>	\$2.9	\$0.7	N/A
<i>Measure 2</i>	N/A	\$2.2	\$2.2
Goal 3	\$36.2	\$37.2	\$37.2
<i>Measure 1</i>	\$2.0	\$2.0	N/A
<i>Measure 2</i>	\$6.3	\$6.4	N/A
<i>Measure 3</i>	N/A	\$17.7	\$17.7
Goal 4	\$2.9	\$3.0	\$3.0
<i>Measure 1</i>	\$1.1	N/A	N/A
Goal 5	\$23.2	\$23.0	\$22.9
<i>Measure 2</i>	\$1.1	\$1.2	N/A
<i>Measure 3</i>	\$0.9	N/A	N/A
<i>Measure 4</i>	\$0.6	\$0.6	N/A
<i>Measure 5</i>	N/A	\$3.0	\$3.0
Goal 6	\$3.8	\$3.8	\$3.7
<i>Measure 1</i>	\$3.4	\$2.9	N/A
<i>Measure 2</i>	N/A	\$0.7	\$0.6
Goal 7	N/A	\$4.4	\$4.4
<i>Measure 1</i>	N/A	\$4.4	\$4.4
Goal 8	N/A	\$6.7	\$6.7
<i>Measure 1</i>	N/A	\$6.7	\$6.7
HIV/AIDS, STD and TB Prevention	\$992.5	\$990.1	\$978.9
<i>HIV/AIDS, Research and Domestic</i>	\$787.2	\$783.7	\$741.2
Goal 1	\$773.8	\$770.3	\$728.6
<i>Measure 1</i>	\$764.4	\$760.9	\$719.7
<i>Measure 2</i>	\$9.4	\$9.4	\$8.9
Goal 2	\$342.4	\$340.9	\$322.4
<i>Measure 1</i>	\$249.7	\$248.6	\$235.1
Goal 3	\$191.1	\$190.3	\$180.0
<i>Measure 1</i>	\$178.5	\$177.7	\$168.0
<i>Measure 5</i>	\$12.7	\$12.6	\$11.9
Goal 4	\$48.6	\$48.4	\$45.7
<i>Measure 1</i>	\$3.9	\$3.8	\$3.6
Goal 5	\$185.3	\$184.5	\$174.5
<i>Measure 1</i>	\$52.9	\$52.7	\$49.8
<i>Sexually Transmitted Diseases</i>	\$161.1	\$162.2	\$160.2
Goal 6	\$93.4	\$94.1	N/A
<i>Measure 2</i>	\$15.8	\$15.9	N/A

Agency for Toxic Substances and Disease Registry Performance Program Summary Table Estimated Full Cost by Program (Dollars in Millions)			
Performance Program Area	FY 2004	FY 2005	FY 2006
<i>Measure 3</i>	\$30.9	\$31.2	N/A
<i>Measure 5</i>	\$46.9	N/A	N/A
Goal 7	\$56.4	\$56.8	N/A
<i>Measure 1</i>	\$49.9	\$50.3	N/A
<i>Measure 2</i>	\$6.4	\$6.5	N/A
Goal 8	\$11.3	\$11.4	N/A
<i>Measure 1</i>	\$11.3	\$11.4	N/A
Goal 9	N/A	N/A	\$89.7
<i>Measure 1</i>	N/A	N/A	\$28.8
<i>Measure 2</i>	N/A	N/A	\$32.0
<i>Measure 3</i>	N/A	N/A	\$30.4
Goal 10	N/A	N/A	\$60.9
<i>Measure 1</i>	N/A	N/A	\$24.0
<i>Measure 1</i>	N/A	N/A	\$19.2
<i>Measure 2</i>	N/A	N/A	\$11.2
<i>Measure 3</i>	N/A	N/A	\$6.4
<i>Tuberculosis</i>	\$139.5	\$141.1	\$139.3
Goal 11	\$139.5	\$141.1	\$139.3
<i>Measure 2</i>	\$97.0	\$98.1	\$96.8
<i>Measure 3</i>	\$12.6	\$12.7	\$12.5
<i>Measure 4</i>	\$27.2	\$27.5	\$27.2
Immunization	\$570.2	\$582.9	\$478.5
Goal 1	\$189.6	\$193.8	\$159.1
<i>Measure 1</i>	\$132.6	\$135.5	\$111.3
<i>Measure 2</i>	\$17.1	\$17.5	\$14.4
<i>Measure 3</i>	\$39.9	\$40.8	\$33.5
Goal 2	\$189.6	\$19,381.1	\$159.1
<i>Measure 1</i>	\$189.6	\$193.8	\$159.1
Goal 3	\$22.8	\$23.3	\$19.1
<i>Measure 1</i>	\$11.4	\$11.7	\$9.6
<i>Measure 2</i>	\$11.4	\$11.7	\$9.6
Goal 4	\$28.5	\$29.1	\$23.9
<i>Measure 1</i>	\$28.5	\$29.1	\$23.9
HEALTH PROMOTION	\$1,006.7	\$1,099.1	\$1,016.5
Chronic Disease Prevention and Health Promotion	\$875.5	\$956.9	\$881.4
Goal 1	\$43.8	\$47.8	\$44.1
<i>Measure 1</i>	\$26.3	\$28.7	\$26.4
<i>Measure 2</i>	\$17.5	\$19.1	\$17.6
Goal 2	\$43.8	\$47.8	\$44.1
<i>Measure 1</i>	\$43.8	\$47.8	\$44.1
Goal 3	\$157.6	\$162.7	\$158.7
<i>Measure 1</i>	\$78.8	\$86.1	\$79.3
<i>Measure 2</i>	\$17.5	\$19.1	\$17.6
<i>Measure 3</i>	\$17.5	\$19.1	\$17.6

Agency for Toxic Substances and Disease Registry Performance Program Summary Table Estimated Full Cost by Program (Dollars in Millions)			
Performance Program Area	FY 2004	FY 2005	FY 2006
<i>Measure 4</i>	\$17.5	\$19.1	\$17.6
<i>Measure 5</i>	\$17.5	\$19.1	\$17.6
Goal 4	\$78.8	\$86.1	\$79.3
<i>Measure 1</i>	\$35.0	\$28.7	\$35.3
<i>Measure 2</i>	\$17.5	\$19.1	\$17.6
<i>Measure 3</i>	\$17.5	\$19.1	\$17.6
Goal 5	\$96.3	\$114.8	\$105.8
<i>Measure 1</i>	\$96.3	\$114.8	\$105.8
Goal 6	\$105.1	\$143.5	\$79.3
<i>Measure 1</i>	\$52.5	\$57.4	\$52.9
Goal 7	\$43.8	\$47.8	\$44.1
<i>Measure 1</i>	\$43.8	\$47.8	\$44.1
<i>Measure 2</i>	\$43.8	\$47.8	\$44.1
Goal 8	\$35.0	\$38.3	\$35.3
<i>Measure 1</i>	\$17.5	\$19.1	\$17.6
<i>Measure 2</i>	\$17.5	\$19.1	\$17.6
Birth Defects, Developmental Disabilities, Disability and Health	\$131.2	\$142.2	\$135.1
Goal 1	\$68.2	\$73.9	\$70.2
<i>Measure 1</i>	\$14.4	\$15.6	\$14.9
<i>Measure 2</i>	\$10.5	\$11.4	\$10.8
<i>Measure 3</i>	\$23.6	\$25.6	\$24.3
Goal 2	\$63.0	\$68.3	\$64.8
<i>Measure 1</i>	\$15.7	\$17.1	\$16.2
<i>Measure 2</i>	\$34.1	\$37.0	\$35.1
HEALTH INFORMATION SERVICES	\$274.5	\$293.3	\$266.1
Health Statistics	\$133.3	\$152.8	\$136.7
Goal 1	\$133.3	\$152.8	\$136.7
<i>Measure 1</i>	\$113.3	\$129.9	\$116.2
Health Marketing	\$60.7	\$60.5	\$57.3
Goal 2	\$12.1	\$12.1	\$11.5
<i>Measure 1</i>	\$2.4	\$2.4	\$2.3
ENVIRONMENTAL HEALTH AND INJURY	\$330.6	\$334.0	\$314.1
Environmental Health	\$177.8	\$179.1	\$163.5
Goal 1	\$32.0	\$32.2	\$29.4
<i>Measure 1</i>	\$10.7	\$10.7	\$9.8
<i>Measure 2</i>	\$7.1	\$7.2	\$6.5
<i>Measure 3</i>	\$14.2	\$14.3	\$13.1
Goal 2	\$80.5	\$81.1	\$74.1
<i>Measure 1</i>	\$32.0	\$32.2	\$29.4
<i>Measure 2</i>	\$42.7	\$43.0	\$39.2
<i>Measure 3</i>	\$3.6	\$3.6	\$3.3
<i>Measure 4</i>	\$2.3	\$2.3	\$2.1
Goal 3	\$16.0	\$16.1	\$14.7
<i>Measure 1</i>	\$16.0	\$16.1	\$14.7

Agency for Toxic Substances and Disease Registry Performance Program Summary Table Estimated Full Cost by Program (Dollars in Millions)			
Performance Program Area	FY 2004	FY 2005	FY 2006
Injury Prevention and Control	\$152.8	\$154.9	\$150.7
Goal 1	\$85.6	\$86.7	\$84.4
<i>Measure 1</i>	\$42.8	\$43.4	\$42.2
<i>Measure 2</i>	\$3.1	\$3.1	\$3.0
Goal 2	\$18.3	\$18.6	\$18.1
<i>Measure 1</i>	\$18.3	\$18.6	\$18.1
Goal 3	\$48.9	\$49.6	\$48.2
<i>Measure 1</i>	\$48.9	\$49.6	\$48.2
OCCUPATIONAL SAFETY AND HEALTH	\$415.9	\$426.2	\$334.4
Occupational Safety and Health	\$415.9	\$426.2	\$334.4
Goal 1	\$266.2	\$319.7	\$250.8
<i>Measure 1</i>	N/A	N/A	\$50.2
<i>Measure 2</i>	\$118.5	\$63.9	N/A
<i>Measure 3</i>	\$118.5	\$289.8	\$227.4
<i>Measure 4</i>	\$29.1	\$29.8	\$23.4
<i>Measure 5</i>	N/A	\$319.7	\$250.8
Goal 2	\$149.7	\$106.6	\$83.6
<i>Measure 1</i>	\$25.0	\$25.6	\$20.1
<i>Measure 2</i>	N/A	\$55.4	\$43.5
<i>Measure 3</i>	\$45.7	\$55.4	N/A
<i>Measure 4</i>	\$58.2	\$51.1	\$40.1
<i>Measure 5</i>	\$20.8	\$25.6	\$20.1
GLOBAL HEALTH	\$303.4	\$311.6	\$309.6
Global Health - GAP	\$147.2	\$146.5	\$139.6
Goal 1	\$147.2	\$146.5	\$139.6
<i>Measure 1</i>	\$147.2	\$146.5	\$139.6
Global Health - Immunization	\$139.8	\$138.9	\$138.8
Goal 3	\$23.8	\$23.6	\$23.6
<i>Measure 1</i>	\$12.6	\$12.5	\$12.5
<i>Measure 2</i>	\$11.2	\$11.1	\$11.1
Goal 4	\$10.5	\$10.4	\$10.4
<i>Measure 1</i>	\$9.1	\$9.0	\$9.0
<i>Measure 2</i>	\$1.4	\$1.4	\$1.4
PUBLIC HEALTH IMPROVEMENT AND LEADERSHIP	\$201.3	\$231.1	\$164.7
BLOCK GRANT	\$132.9	\$131.9	-
TERRORISM	\$1,544.5	\$1,600.1	\$1,639.8
Goal 1	\$656.4	\$768.0	\$768.6
<i>Measure 1</i>	N/A	\$96.0	\$114.8
<i>Measure 2</i>	\$77.2	N/A	N/A
<i>Measure 3</i>	\$77.2	\$96.0	\$131.2
<i>Measure 4</i>	\$30.9	\$32.0	\$32.8
<i>Measure 5</i>	\$30.9	\$32.0	\$82.0
<i>Measure 6</i>	\$77.2	\$80.0	\$32.8
<i>Measure 7</i>	N/A	\$64.0	\$82.0
<i>Measure 8</i>	N/A	\$32.0	\$49.2
<i>Measure 9</i>	\$77.2	\$128.0	N/A
<i>Measure 10</i>	\$61.8	N/A	N/A

Agency for Toxic Substances and Disease Registry Performance Program Summary Table Estimated Full Cost by Program (Dollars in Millions)			
Performance Program Area	FY 2004	FY 2005	FY 2006
Measure 11	\$54.1	N/A	N/A
Measure 12	N/A	\$32.0	\$82.0
Measure 13	\$46.3	\$48.0	\$49.2
Measure 14	\$46.3	\$48.0	\$32.8
Measure 15	\$77.2	N/A	N/A
Measure 16	\$22.5	\$22.9	\$23.8
Goal 2	\$355.2	\$304.0	\$278.8
Measure 1	N/A	\$48.0	\$65.6
Measure 2	\$38.6	N/A	N/A
Measure 3	\$38.6	N/A	N/A
Measure 4	N/A	\$80.0	\$82.0
Measure 5	\$30.9	\$32.0	\$32.8
Measure 6	\$30.9	N/A	N/A
Measure 7	\$30.9	N/A	N/A
Measure 8	\$30.9	N/A	N/A
Measure 9	\$77.2	\$80.0	N/A
Measure 10	N/A	\$64.0	\$98.4
Measure 11	\$77.2	N/A	N/A
Goal 3	\$239.4	\$272.0	\$328.0
Measure 1	N/A	\$32.0	\$32.8
Measure 2	\$77.2	\$80.0	\$82.0
Measure 3	\$162.2	\$192.0	\$246.0
ATSDR	\$72.43	\$72.43	\$72.43
Goal 1	\$23.70	\$23.70	\$23.70
Measure 1	\$23.70	\$23.70	\$23.70
Goal 2	\$35.53	\$35.53	\$35.53
Measure 1	\$15.84	\$15.84	\$15.84
Measure 2	\$19.69	\$19.69	\$19.69
Goal 3	\$13.19	\$13.19	\$13.19
Measure 1	\$10.92	\$10.92	\$10.92
Measure 2	\$2.28	\$2.28	\$2.28

The FY 2004 – FY 2006 estimates of the full cost of CDC programs was estimated by adding program management cost to the budget authority levels from the All Purpose Table in CDC's FY 2006 Congressional Justification. Program management costs included CDC's Leadership & Management and Business Services Support activities as well as Buildings & Facilities activities. Program management costs were allocated, where appropriate, across performance program areas based on the proportion of total program level cost represented by each program and performance program area.

The full cost of each performance program area was then distributed by performance measures. These distributions are based on professional judgments, supported to the extent possible by financial and other statistical data. In many cases, performance measures are aggregated in the distributions of cost because of the interdependence of the activities and goals represented by the measures.

The cost distributions by performance measures are presented for "active" measures in a given year. That is, measures that are to be deleted are included only for the applicable year(s) before their deletion; new measures are included beginning with the first year in which performance data are expected. When the cost distributions by performance measure do not add to total cost for that performance program area, explanatory notes are provided.

EXHIBIT W. CHANGES AND IMPROVEMENTS OVER PREVIOUS YEAR

From FY 2002 to 2006, CDC reduced the total number of measures included its Performance Plan by 33 percent. In addition, the proportion of outcome measures to the total number of measures increased from 24 to 43 percent.

Several changes from the FY 2005 GPRA plan are included in the CDC FY 2006 Congressional Justification. These include the reorganization of the CDC organization, budget, and performance structures and the addition of new PART measures. More changes related to the Futures Initiative and Goals Management are expected for the FY 2007 Congressional Justification

REORGANIZATION OF CDC ORGANIZATION, BUDGET AND PERFORMANCE STRUCTURES

The FY 2006 Congressional Justification is CDC's first submission to Congress combining budget and performance information into one document. In addition, this Congressional Justification is organized according to the agency's new budget structure. The new budget structure embraces the reorganization of CDC through the Futures Initiative and better supports the agency's core public health mission. The structure facilitates a transparent system of accountability and helps to maximize CDC's public health impact.

CDC's performance structure (including GPRA programs and goals) has also been reorganized to align with the new budget structure. In general, each budget activity corresponds with a GPRA program. The table below illustrates the relationship between budget activities and GPRA programs.

NEW BUDGET ACTIVITY	NEW GPRA PROGRAM	PREVIOUS GPRA PROGRAM
Infectious Diseases	Infectious Diseases	<ul style="list-style-type: none"> • HIV/AIDS Prevention (Domestic), Sexually Transmitted Diseases, Tuberculosis • Immunization (Domestic) • Infectious Diseases Control
Health Promotion	Health Promotion	<ul style="list-style-type: none"> • Birth Defects, Developmental Disabilities, Disability and Health • Chronic Disease Prevention and Health Promotion • Portions of Public Health Improvement
Health Information and Service	Health Information and Service	<ul style="list-style-type: none"> • Health Statistics • Portions of Epidemic Services and Response • Portions of Public Health Improvement
Environmental Health and Injury	Environmental Health and Injury	<ul style="list-style-type: none"> • Environmental Health • Injury Prevention and Control
Occupational Safety and Health	Occupational Safety and Health	<ul style="list-style-type: none"> • Occupational Safety and Health
Global Health	Global Health	<ul style="list-style-type: none"> • HIV/AIDS Prevention (Global AIDS Program) • Immunization (Global)
Public Health Research	N/A	N/A
Public Health Improvement and Leadership	Public Health Improvement and Leadership	<ul style="list-style-type: none"> • Office of the Director • Portions of Epidemic Services and Response • Portions of Public Health Improvement
Preventive Health and Health Services Block Grant	Preventive Health and Health Services Block Grant	<ul style="list-style-type: none"> • Preventive Health and Health Services Block Grant
Buildings and Facilities	Buildings and Facilities	<ul style="list-style-type: none"> • Buildings and Facilities
Business Services and Support	N/A	N/A
Terrorism	Terrorism	<ul style="list-style-type: none"> • Terrorism • Portions of Public Health Improvement
Reimbursements and Trust Funds	N/A	N/A

PART MEASURES

Five CDC programs were reviewed during the FY 2006 PART cycle. As a result of the reviews, CDC incorporated 23 new PART measures into its FY 2006 Performance Plan. These measures include 11 outcome, 9 output, and 3 efficiency measures.

EXHIBIT X. LINKS TO HHS AND CDC STRATEGIC PLANS

The table below illustrates links from CDC's GPRA goals to the HHS Strategic Plan. Note that efficiency goals are not included in this table.

GPRA PROGRAM	GPRA GOAL	HHS STRATEGIC GOAL
Infectious Diseases	Protect Americans from infectious diseases—hepatitis c, chronic liver disease, and viral hepatitis.	1, 4
	Protect Americans from infectious diseases—influenza.	1, 4, 5
	Protect Americans from infectious diseases—foodborne illnesses.	1, 2
	Protect Americans from infectious diseases—group B streptococcal infections.	1
	Reduce the spread of antimicrobial resistance.	1, 4, 5
	Protect Americans from death and serious harm caused by medical errors and preventable complications of healthcare.	1, 5
	Protect Americans from infectious diseases – pneumococcal disease.	1
	Protect Americans from infectious diseases – laboratory response.	4, 5
	By 2010, reduce by 25% the number of new HIV infections in the U.S., as measured by a reduction in the number of HIV infections diagnosed each year among people under 25 years of age, from 2,100 in 2000 to approximately 1,600 in 2010.	1
	Decrease the number of persons at high risk for acquiring or transmitting HIV infection.	1
	By 2010, increase by 13% the proportion of HIV-infected people who know they are infected, as measured by the proportion diagnosed before progression to AIDS (Baseline: 76% in 2000; Target for 2010: 85%).	1
	By 2010, increase to at least 80% the proportion of HIV-infected people who are linked to appropriate prevention, care, and treatment services, as measured by those who report having received some form of medical care within 3 months of their HIV diagnosis (2001 Baseline: 79%).	1, 4
	Strengthen the capacity nationwide to monitor the epidemic; develop and implement effective HIV prevention interventions; and evaluate prevention programs.	1
	Reduce STD rates by providing chlamydia and gonorrhea screening, treatment, and partner treatment to 50% of women in publicly funded family planning and STD clinics nationally.	1
	Reduce the incidence of P&S syphilis.	1, 3
	Reduce the incidence of congenital syphilis.	1
	By 2010, reduce the incidence of pelvic inflammatory disease (PID) by 15% (as measured by initial visits to physicians by women ages 15-44).	1
	Reduce the incidence of primary and secondary (P&S) syphilis by 12% and congenital syphilis by 62%.	1, 3
	Progress towards TB elimination in the U. S. (defined as less than 1 case/1,000,000 population) by achieving an interim TB rate of 1 case/100,000 population in U.S.-born persons and 20 cases/100,000 population in foreign-born persons residing in the U. S., and 3 cases/100,000 population overall, by 2010.	1, 5
	Reduce the number of indigenous cases of vaccine-preventable diseases.	1
Ensure that 2-year-olds are appropriately vaccinated.	1	
Increase the proportion of adults who are vaccinated annually against influenza (flu) and ever vaccinated against pneumococcal disease.	1	
Improve vaccine safety surveillance.	1, 2, 4	
Health Promotion	Reduce death and disability due to heart disease and stroke and eliminate disparities.	1, 5, 6
	Increase early detection of breast and cervical cancer by building nationwide programs in breast and cervical cancer prevention, especially among high-risk, underserved women.	1

GPRA PROGRAM	GPRA GOAL	HHS STRATEGIC GOAL
	Expand community-based breast and cervical cancer screening and diagnostic services to low income, medically underserved women. For women diagnosed with cancer or pre-cancer, ensure access to treatment services.	1, 3, 5, 6
	Increase the capacity of state diabetes control programs to address the prevention of diabetes and its complications at the community level.	1, 3, 6
	Reduce cigarette smoking among youth.	1, 7
	Decrease levels of obesity, or reduce the rate of growth of obesity, in communities through nutrition and physical activity interventions.	1, 5
	Reduce the percentage of HIV/AIDS-related risk behaviors among school-aged youth through dissemination of HIV prevention education programs.	1, 2, 5, 7
	By 2010, improve the lives of racial and ethnic populations who suffer disproportionately from the burden of disease and disability, and develop tools and strategies that will enable the nation to eliminate these health disparities.	1, 3, 4
	Prevent birth defects and developmental disabilities.	1, 4, 5
	Improve the health and quality of life of Americans with disabilities.	3, 5, 6
Health Information and Service	Monitor trends in the nation's health through high-quality data systems and deliver timely data to the nation's health decision-makers.	5
	Develop a national, integrated, standards-based public health surveillance infrastructure that is securely linked to healthcare practice.	5
	By 2006, CDC will develop and implement training to provide for an effective, prepared, and sustainable health workforce able to meet emerging health challenges.	5
	Increase the number of frontline public health workers at the state and local level that are competent and prepared to respond to bioterrorism, infectious disease outbreaks, and other public health threats and emergencies; and prepare frontline state and local health departments and laboratories to respond to current and emerging public health threats.	4
Environmental Health and Injury	Determine human health effects associated with environmental exposures.	1, 2, 4, 5
	Prevent or reduce illnesses, injury, and death related to environmental risk factors.	1, 2
	Build and enhance effective partnerships to improve environmental health capacity.	4, 5
	Increase the capacity of injury prevention and control programs to address the prevention of injuries and violence.	1
	Monitor and detect fatal and non-fatal injuries.	5
	Conduct a targeted program of research to reduce injury-related death and disability.	4
Occupational Safety and Health	Conduct research to reduce work-related illnesses and injuries.	4
	Promote safe and healthy workplaces through interventions, recommendations and capacity building.	1, 2, 4
Global Health	By 2010, work with other countries, international organizations, the U.S. Department of State, USAID, and other partners to achieve the united nations general assembly special session on HIV/AIDS goal of reducing prevalence among 15 to 24 years of age.	
	Counsel, test, and treat up to 1 million pregnant women and reduce mother to child transmission by up to 40% among women treated, by working with USAID.	
	Help domestic and international partners achieve World Health Organization's goal of global polio eradication.	1
	Work with global partners to reduce the cumulative global measles-related mortality rate.	1

SUPPORTING INFORMATION
EXHIBIT X. LINKS TO HHS AND CDC STRATEGIC PLANS

GPRA PROGRAM	GPRA GOAL	HHS STRATEGIC GOAL
Public Health Improvement and Leadership	Prepare minority medical, veterinary, pharmacy, and graduate students for careers in public health.	
	Support HBCUS, Hispanic serving institutions, and tribal colleges and institutions.	
	Foster a stronger collective departmental perspective on AI/AN issues.	3
	By 2006, CDC will develop and implement training to provide for an effective, prepared, and sustainable health workforce able to meet emerging health challenges.	2, 4, 8
	Increase the number of frontline public health workers at the state and local level that are competent and prepared to respond to bioterrorism, infectious disease outbreaks, and other public health threats and emergencies; and prepare frontline state and local health departments and laboratories to respond to current and emerging public health threats.	2, 4, 5
Buildings & Facilities	Implement scheduled improvements, construction, security, and maintenance consistent with available resources and priorities identified in CDC's master facilities planning process.	
Terrorism	Rapidly detect public health emergencies involving CBRN agents.	2, 4, 5
	Rapidly investigate and respond to public health emergencies involving CBRN agents.	2, 5
	Rapidly control, contain, and recover from public health emergencies involving CBRN agents.	4, 5

EXHIBIT Y. PARTNERSHIPS AND COORDINATION

INFECTIOUS DISEASES

INFECTIOUS DISEASES CONTROL

To accomplish its mission of protecting the public from infectious disease threats, CDC collaborates with a number of agencies and organizations. Examples of partners and some selected activities include: the Council of State and Territorial Epidemiologists (CSTE) which assists states with pandemic influenza planning activities, Association of Public Health Laboratories (APHL) to enhance state laboratory capacity by providing long-term laboratory training, National Institutes of Health (NIH), Food and Drug Administration (FDA) (food safety programs), USDA (food safety programs), Department of Interior (U.S. Fish and Wildlife Service), Department of Justice (U.S. Immigrations and Naturalization Service), Department of State and Department of Treasury (U.S. Customs). To accomplish HCV prevention objectives, CDC collaborates with the National Association of State and Territorial AIDS Directors (NASTAD), National Minority AIDS Council (NMAC), American Social Health Association (ASHA), Pacific Islands Health Officers Association (PIHOA), American Liver Foundation (ALF), Hepatitis Foundation International (HFI), and Indian Health Service (IHS).

HIV / AIDS, STD AND TB PREVENTION

HIV/AIDS

CDC works closely with other HHS agencies, including HRSA, SAMHSA and NIH to coordinate efforts to address HIV. CDC works with HRSA to evaluate access to care and the extent to which states have been effective in reducing perinatal HIV transmission; provides data necessary for HRSA's care and treatment programs; and is closely coordinating with them to implement the Advancing HIV Prevention Initiative.

CDC collaborates with SAMHSA and NIDA on issues related to transmission of HIV in the injecting drug use population. A working group has been established to address healthcare issues in correctional institutions. Development and implementation of the plan to eliminate racial and ethnic health disparities is an interagency effort within HHS. CDC works closely with USAID, UNAIDS cooperating agencies (WHO, UNICEF, UNDP, UNFPA), sister agencies in HHS, other federal agencies, and U.S.-based non-governmental organizations working in HIV prevention in Global AIDS countries and regions. In particular, CDC is one of the implementing agencies of the President's Emergency Plan for AIDS Relief (Emergency Plan), working closely with USAID and other parts of HHS, under the direction of the Global AIDS Coordinator in the State Department.

SEXUALLY TRANSMITTED DISEASES

CDC works with partners to educate health professionals and the public about the importance of STD prevention, the importance of protective healthcare-seeking and personal sexual behaviors, and the impact of STDs on the health of Americans, particularly women and infants, adolescents, and minority populations. Two major foci of national STD efforts are prevention of STD-related infertility and syphilis elimination.

INFERTILITY PREVENTION PROGRAM

CDC and the Office of Population Affairs (OPA), Indian Health Service (IHS), and Association of Public Health Labs (APHL) work collaboratively with family planning, STD, and primary-care programs to provide surveillance, screening, treatment, laboratory, and program-relevant research activities to inform and help in the implementation of infertility prevention activities for uninsured and under-insured women.

SYPHILIS ELIMINATION

At least 30 percent of federal grant funds are provided to non-governmental agencies and organizations that represent and serve affected populations. Among the many national and local partners working to implement syphilis elimination efforts are NIH, HRSA, SAMHSA, NIJ, APHL, and the American Social Health Association (ASHA). Collaborative efforts include: providing technical guidance on clinical services, implementing research and demonstration projects, and promoting collaboration among local affiliates/constituents on elimination efforts. One such example is the Community Health Outreach Education Services (CHORES) collaboration led by HRSA to integrate into primary care a comprehensive health promotion, health education, and disease prevention program. Five sites selected from CDC-designated high-morbidity areas will focus on implementing prevention into primary care programs and community involvement.

TUBERCULOSIS

CDC works with state, large city and territorial health departments to deliver TB prevention and intervention activities designed to reduce the incidence of TB and eventually eliminate the disease. CDC works with the HHS Advisory Council for the Elimination of Tuberculosis (ACET), the National TB Controllers Association, American Lung Association, American Thoracic Society (ATS), and Infectious Diseases Society of America to set guidelines, recommendations, and policies related to TB prevention, control, and elimination. CDC is working with the Federal TB Task Force to develop a federal action plan in response to the Institute of Medicine (IOM) report, *Ending Neglect: The Elimination of Tuberculosis* in the U. S. CDC works with NIH and FDA to develop new diagnostic and treatment tools and better vaccines. Through contracts with academic institutions and public health departments and interagency agreements (with the Veterans Health Administration), CDC formed a consortium for clinical trials research (currently evaluating the new TB drug, rifapentine) and a consortium for epidemiological and operational research. Internationally, CDC collaborates with USAID, the World Health Organization (WHO), and others through efforts such as the Stop TB Initiative and through assistance to specific countries.

IMMUNIZATION

DOMESTIC IMMUNIZATION

The 317 Immunization Program works to ensure that children, adolescents, and adults receive appropriate immunizations by working in partnership with health providers in the public and private sector. The program helps assure the implementation of effective immunization practices and proper use of vaccines to achieve high immunization coverage, and supports infrastructure for essential activities such as immunization registries, disease surveillances, outbreak control education and service delivery.

The VFC program is CDC's largest public/private partnership. The VFC program is a state-operated, federal entitlement program that removed vaccine cost as a barrier to immunization for our neediest children. Based on the total doses of routinely recommended pediatric vaccines distributed in the U.S., the VFC program served about 42 percent of the childhood population in 2003. Over 42,000 provider sites are enrolled in the VFC program and 30,000 of these are private provider sites. The VFC program provides public-purchased vaccine to all enrolled providers who agree to vaccinate VFC eligible children aged birth through 18 years of age.

CDC's Advisory Committee on Immunization Practices (ACIP) continually reviews recommendations for adult and adolescent immunization and for the childhood immunization schedule to ensure that it recommended the safest and most efficient protection. Three advisory bodies collaborate to issue a single schedule of routine childhood immunizations: the ACIP, the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP). The schedule is continually evaluated to ensure the highest level of effectiveness, efficiency, and safety in childhood immunizations.

CDC's National Immunization Program and the American Medical Association co-sponsored the 2004 National Influenza Summit in April 2004. The summit brought together 139 representatives from 69 organizations. The meeting featured presentations and moderated breakout sessions that focused on three themes: 1) influenza vaccine production, distribution, and allocation; 2) influenza vaccine recommendations; and 3) vaccine administration and influenza prevention. A summary report of the breakout group discussions highlighted key actions for Summit members to pursue in preparation for the 2004 - 2005 season. The Summit has an Executive Committee and nine working groups available year round to advise or respond to influenza vaccine-related issues. The working groups are as follows: Communications, Payment for Vaccine and its Administration, Vaccine Distribution, Community Vaccine Providers, Occupational Health and Business, Long Term Care, Physicians, Community Vaccine Reallocation, and Consumers.

CDC collaborated with federal partners in the development of the Pandemic Influenza Preparedness and Response Plan, which was submitted to the Department of Health and Human Services. The goal of this plan is to limit the total burden of disease caused by an influenza pandemic, and to reduce social disruption and economic loss. CDC collaborated with the Council of State and Territorial Epidemiologists (CSTE) to assist state and local public health and emergency management agencies in developing their pandemic influenza plans.

Together with international partners, CDC helps to reduce illness and death caused by vaccine preventable diseases by strengthening routine immunization activities and building a strong platform for the introduction of new vaccines in the developing world.

HEALTH PROMOTION

CHRONIC DISEASE PREVENTION, HEALTH PROMOTION AND GENOMICS

Chronic diseases are a community-wide burden. CDC works with state and local health and education agencies, healthcare organizations, academic institutions, national organizations, nonprofit agencies, business, and philanthropies to reduce the burden of chronic diseases.

HEART DISEASE AND STROKE

CDC has a signed memorandum of understanding with the American Heart Association, Centers for Medicare and Medicaid Services, Office of Disease Prevention and Health Promotion, National Institute of Neurological Disorders and Stroke and the National Heart, Lung, and Blood Institute. CDC partners with the National Stroke Association to increase the awareness of stroke disabilities and to enhance national stroke surveillance activities. CDC also collaborates with the Health Resources and Services Administration to improve cardiovascular performance measures through improved care delivery systems, increased access and decreased health disparities among the medically underserved populations in federally qualified health centers. Additionally, CDC partners with the Veteran's Administration to develop and institute a system of enhanced computerized clinical reminders, which provides feedback on risk factor control and suggests treatment changes to encourage compliance with cardiovascular clinical guidelines. Finally, CDC partners with the American College of Cardiologists and the Association of Black Cardiologists to enhance provider compliance with guidelines and encourage collaboration with state health departments.

CANCER PREVENTION AND CONTROL

Partnerships are critical to the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) cancer control efforts. A successful national program to control breast and cervical cancers depends on the involvement of a variety of committed partners and national organizations.

CDC collaborates with state, tribal, and territorial health agencies; healthcare professionals and organizations; human service and voluntary organizations; and academia. The NBCCEDP strategic plan identifies partnership development activities with stakeholders internal and external to CDC including the American Cancer Society, the National Cancer Institute, the Center for Medicaid and Medicare Services, the NBCCEDP Council, National Indian Women's Health Resource Center (NIWHRC), the American College of Obstetricians and Gynecologists, CDC's WISEWOMAN Program and CDC's comprehensive cancer control initiative. Our relationships with these partners are critical to leveraging resources and increasing efficiencies across and within our agencies.

NATIONAL PROGRAM OF CANCER REGISTRIES (NPCR)

Together, the NPCR and the National Cancer Institute's (NCI) Surveillance, Epidemiology and End Results (SEER) registry program collect cancer data for the entire U.S. population. In addition, CDC coordinates with NCI, the American Cancer Society, the American Joint Committee on Cancer, the American College of Surgeons, the North American Association of Central Cancer Registries, and the National Cancer Registrars Association in a special consortium--the National Coordinating Council for Cancer Surveillance (NCCCS). The NCCCS provides a forum through which these organizations can collaborate on cancer monitoring and registry operations, thus helping to ensure that the needs of cancer patients and the communities in which they live are fully served; that scarce resources are maximally used; and that the burden of cancer in the nation is adequately measured and ultimately reduced.

DIABETES PREVENTION AND CONTROL PROGRAMS

CDC and NIH provide federal leadership for the development, coordination and implementation of the National Diabetes Education Program (NDEP). CDC has primary responsibility for coordinating the NDEP Partnership Network of more than 200 organizations, coordinating several of the 10 NDEP planning workgroups and administering the NDEP community interventions component. CDC collaborates with IHS and other organizations to conduct the research and training activities of the National Diabetes Prevention Center (NDPC). The NDPC was established to address the serious diabetes epidemic in American Indians. CDC's state-based diabetes control programs partner with community health centers to improve the health status of persons with diabetes who receive care at these sites. CDC also collaborates with state health departments, American Diabetes Association, American Public Health Association, Juvenile Diabetes Research Foundation, American Association of Diabetes Educators and managed-care organizations in the control of diabetes and its complications.

TOBACCO USE PREVENTION

While CDC serves as a focal point for HHS tobacco prevention activities, prevention or reduction of tobacco use is a shared effort across multiple agencies in HHS and state and local governments, non-governmental organizations (e.g., American Cancer Society, Robert Wood Johnson Foundation) and healthcare providers. CDC works with community-based programs, health communication campaigns and schools to prevent and reduce smoking among youth. It is important to note that marketing and other factors (e.g., tobacco advertising, industry pricing patterns, glamorization of tobacco use in the popular media) can counteract efforts to reduce tobacco use.

NUTRITION, PHYSICAL ACTIVITY PROGRAMS TO PREVENT OBESITY AND OTHER CHRONIC DISEASES

CDC focuses on several strategies to decrease obesity and chronic disease rates by increasing physical activity and good nutrition, mainly through partnerships. Major partnerships on physical activity include the Robert Wood Johnson Foundation's initiative on environmental and policy influences on physical activity, American College of Sports Medicine, U.S. Department of Transportation, National Parks Service, President's Council on Physical Fitness and Sports and the National Association for Sports and Physical Education. Key nutrition and obesity partnerships include the U.S. Department of Agriculture, National Institutes of Health, American Cancer Society, Produce for Better Health Foundation, American Academy of Pediatrics and CDC Prevention Research Centers.

ARTHRITIS PROGRAMS

CDC and its principal partners – arthritis programs in state health departments and the Arthritis Foundation – are working to increase awareness of arthritis and its impact. In addition, they are working to increase appropriate self management behaviors that have been shown to be effective in reducing pain and improving function. CDC also works with the Arthritis Council of the Chronic Disease Directors Association and the State and Territorial Directors for Health Promotion and Public Health Education to achieve these program goals.

ORAL HEALTH PROGRAMS

CDC is a leader in facilitating collaborative activities called for by A National Call to Action to Promote Oral Health, a national planning process to improve the nation's oral health that was implemented in 2003. CDC is working with representatives of the national Partnership Network, a group of more than 75 representatives from national health, nonprofit and trade organizations, foundations and federal agencies to advance the five strategies detailed in the Call to Action. This initiative grew out of the attention generated by the publication of the first Surgeon General's report on oral health, *Oral Health in America* (May 2000).

CDC, along with the federal co-lead agencies for the Healthy People 2010 initiative on oral health, has strategic partnerships with two major dental professional organizations (Academy of General Dentistry and American Association for Dental Research) to foster progress toward specific HP 2010 objectives.

SCHOOL HEALTH PROGRAMS

For HIV Prevention among School-aged Youth, data is collected on a biennial basis (during odd-numbered years) through CDC's Youth Risk Behavior Surveillance System (YRBSS), a system designed to focus attention on priority behaviors among youth that are associated with the most important health problems. The YRBSS was developed in partnership with federal agencies, state departments of education and health, scientific experts and survey research specialists. The YRBSS includes separate national, state and local school-based surveys of high school students.

PREVENTION RESEARCH CENTERS

The PRCs work through established partnerships among state and local health departments, community-based organizations, and other stakeholders to conduct research on chronic diseases and their determinants as well as some injuries (e.g., workplace hazards) and infectious diseases (e.g. risk for HIV infection).

RACIAL AND ETHNIC APPROACHES TO COMMUNITY HEALTH (REACH) 2010

In addition to CDC, other HHS agencies and offices have played critical roles in planning, coordinating, and supporting REACH 2010. These include the National Institutes of Health, National Center for Minority Health and Health Disparities, the Administration on Aging, the Office of the Secretary, the Health Resources and Services Administration and the Agency for Healthcare Research and Quality.

STEPS TO A HEALTHIER US

The Steps Program has established strong relationships with HHS sister agencies, CDC categorical programs, and the public health community to ensure an inclusive Steps program that incorporates the skills, resources, and input of the public health community at all levels. A Prevention Steering Committee made up of representatives from each

HHS agency, a CDC Division Liaison Workgroup, and a Steps Partner Workgroup comprised of national partners and public health leadership organizations were established to provide ongoing oversight and coordinate technical assistance to the funded Steps communities. In addition, Steps communities are required to integrate at the local level by establishing an alliance of partnerships and coalitions committed to participating actively in the planning, implementation, and evaluation of Steps.

BIRTH DEFECTS, DEVELOPMENTAL DISABILITIES, DISABILITY AND HEALTH

CDC works in partnership with state health departments, healthcare professional organizations, academic institutions, and many non-profit organizations. Specific examples are given below.

Programs for monitoring birth defects, developmental disabilities and the health of people with disabilities are done in partnership with state health departments and with a university and other non-profit organization acting as an agent for the state health department. Non-profit organizations such as the March of Dimes conduct special surveys on risk factors such as folic acid consumption to assist CDC in monitoring effectiveness of health promotion campaigns. The Early Hearing Detection and Intervention programs are implemented by state health departments but a partner organization, the Directors of Speech and Hearing Programs in State Health and Welfare Agencies, collect and make available the data. CDC also works closely with colleagues in the Health Resources and Services Administration (HRSA), the U.S. Department of Education in these efforts. Efforts to monitor fetal alcohol syndrome (FAS) prevent this condition before it begins, and develop and deliver interventions for children with FAS are conducted by state health departments, universities, or both. A variety of partners are involved with developing and disseminating educational materials about FAS. CDC is working with the Autism Society of America and other partners to develop and launch a campaign to increase awareness and early detection of autism and other developmental disabilities.

Several organizations such as the Amputee Coalition of America, the Christopher Reeve Paralysis Foundation, Children and Adults with Attention-Deficit Disorder and National Information Center for People with Disability help CDC provide information to improve the lives of people living with disability.

HEALTH INFORMATION AND SERVICE

HEALTH STATISTICS

CDC collaborates with the HHS Data Council, the National Committee on Vital and Health Statistics, representatives from the states, users of CDC data in the public and private sectors, and other Federal agencies. Close cooperation with state vital statistics offices ensures timely reporting of data. CDC collaborates with these groups on the following topics: defining data needs; addressing issues in methodology, survey design, data quality, confidentiality, and data standards; data collection; data analysis and policy development; data dissemination with regard to facilitating access and use; and developing the public health workforce of the future. The Reimbursable Work Program (RWP), an additional aspect of CDC collaboration in health statistics with the public and private sectors and other federal agencies, was established for the purpose of collecting and analyzing health data. The RWP allows CDC to work directly with other agencies to provide information on topics to support their mission and program information needs using integrated data collection mechanisms managed by CDC. This collaboration provides other agencies and organizations access to the large and diversified staff of technical experts in health statistics at CDC. These agencies include virtually all institutes of NIH, ASPE, HRSA, FDA, AHRQ, ACYF, EPA, HUD, USDA, DOE and other non-governmental organizations. There are many topics of collaboration that range from reproductive health and immunization, to cancer screening, long term care, and industry and occupational mortality. The RWP produces approximately 100 interagency agreements per year.

ENVIRONMENTAL HEALTH AND INJURY

ENVIRONMENTAL HEALTH

FEDERAL AGENCIES

CDC partners with numerous federal agencies including the Departments of Defense, Energy, Homeland Security, the Food and Drug Administration and the U.S. Environmental Protection Agency. The CDC laboratory works closely with EPA and FDA to apprise them of developments, share information and learn about issues of concern related to biomonitoring and CDC's *National Report on Human Exposure to Environmental Chemicals*. CDC and EPA signed a memorandum of understanding (MOU) to achieve mutual environmental goals with regard to environmental public health tracking. EPA will work with CDC to strengthen the bridge between the environmental and public health communities and achieve a better understanding of the links among environmental hazards, ensuing human exposure and potential health outcomes.

NATIONAL ORGANIZATIONS

CDC partners with many national organizations through formal cooperative agreements and grants to work on specific projects that meet the needs of the environmental public health field. Examples of cooperative agreements include an environmental health project and environmental public health tracking project with the Association of State and Territorial Health Officials (ASTHO), a workforce development project with ASTHO, and the National Environmental Health Association (NEHA).

CDC and the Association of Public Health Laboratories cosponsor the Newborn Screening Quality Assurance Program (NSQAP), which provides services to all 50 states, the District of Columbia, and U.S. territories. The program's quality-control assurance services have been critical to the resolution of a recent FDA recall of an assay kit used by newborn screening laboratories. As a result, a shortage of newborn testing kits was avoided in many states. CDC funds \$500,000 to professional national organizations to develop educational materials and tools to promote environmental public health tracking to state health officials and other critical partners. ASTHO is working with NEHA and the Environmental Council of States (ECOS) to assist in teaching unfunded states about environmental public health tracking and bridging the gap between health agencies and environmental agencies. CDC also participates in and promotes partnerships among government agencies, nonprofit groups, and the private sector, including managed care and health care organizations for controlling asthma. CDC's National Asthma Control partners include the Allergy and Asthma Network/Mothers of Asthmatics, the American Academy of Allergy, Asthma, and Immunology, and many others.

ACADEMIC INSTITUTIONS

CDC scientists conduct biomonitoring work with academic institutions and others on more than 50 studies per year. These studies examine the health effects of human exposure to particular environmental chemicals. For example, in California's intensively farmed Salina Valley, about 495,000 pounds of organophosphate pesticides are used on fruits and vegetables each year. As part of a prospective birth cohort study, CDC is collaborating with the University of California at Berkeley on a study to measure levels of the pesticides in pregnant women. Results of these measurements, along with data about birth outcomes, can be used to investigate possible hormone-mediated effects of pesticide exposure. Thus far, the data suggest that exposure to pesticides during a woman's pregnancy can significantly decrease her child's gestational age.

INTERNATIONAL RELATIONSHIPS

CDC has created partnerships with international organizations such as the World Health Organization (WHO). As a result of ongoing collaboration with Xavier Bonnefoy, Regional Advisor on Environment and Health for Europe (Bonn Office), Dr. Richard J. Jackson, former Special Advisor to the Director, CDC, visited WHO to help develop a European declaration on the relation between housing and health. The declaration was presented to high-level health and housing officials of more than 50 WHO member countries at a June 2004 European Conference in Budapest.

COLLABORATION PARTNERSHIPS

Collaboration between CDC partners occurs when appropriate to achieve desired goals and objectives. For example, CDC scientists collaborate on DNA banking and genetics studies with academic institutions, such as the University of Maryland; research entities, such as St. Jude's Children's Research Center; other CDC groups, including the National Center for Health Statistics, the National Center for Birth Defects and Developmental Disabilities, and the National Center for Chronic Disease Prevention and Health Promotion; and state public health departments (e.g., Nevada State Health Division). Laboratory scientists partner with the American Association for Clinical Chemistry; the U.S. Food and Drug Administration; and the National Heart, Lung, and Blood Institute.

Established collaborations exist for diabetes and molecular risk assessment with academic institutions, such as George Washington University and the University of Minnesota; the Juvenile Diabetes Research Foundation, the Immunology of Diabetes, the Joslin Diabetes Center, and the National Institute of Diabetes and Digestive and Kidney Diseases.

INJURY PREVENTION AND CONTROL

Partnerships are critical to realizing CDC's vision to prevent injuries and improve outcomes for those who are injured. Preventing injuries requires the support and contributions of many partners: federal agencies, state and local health departments, non-profit organizations, academic institutions, international agencies, health care providers, and private industry. CDC works with state and local health departments and groups including the State and Territorial Injury Program Directors Association (STIPDA), the Association of State and Territorial Health Officials (ASTHO), and the National Association of City and County Health Officials (NACCHO) to develop, implement, and evaluate injury prevention strategies and programs.

CDC also partners with national professional organizations to disseminate information and support their efforts relating to injury prevention and control including the American Academy of Pediatrics (AAP), the American Psychological Association (APA), the American Trauma Society (ATS), and the American College of Surgeons Committee on Trauma. To ensure the future of injury prevention work, CDC collaborates with organizations including the National Association of Injury Control Research Centers (NAICRC), the Association of Schools of Public Health (ASPH) and the Association of American Medical Colleges (AAMC) to support the development of injury research infrastructure, training, and to build an evidence base for injury prevention and control.

Additionally, CDC collaborates with partners who focus on specific areas of interest such as family violence (Family Violence Prevention Fund), childhood unintentional injuries (National SAFE KIDS Campaign), traumatic brain injury (Brain Injury Association of America) and suicide (SPAN – Suicide Prevention Action Network USA).

To ensure CDC's efforts are complementary and draw on the expertise of other federal agencies, CDC's federal partners include the National Highway Traffic Safety Administration (NHTSA), the Administration on Child and Families (ACF), the National Institutes of Health (NIH), the Substance Abuse and Mental Health Services Administration (SAMHSA), the Health Resources Services Administration (HRSA), the Office of Disease Prevention and Health Promotion at the Department of Health and Human Services (ODPHP), the Department of Education, and the Department of Justice. Without these partnerships, CDC would not be able to effectively address injuries at the state and community level.

OCCUPATIONAL SAFETY AND HEALTH

Through National Occupational Research Agenda (NORA), partnerships have continued between CDC and over 500 organizations to ensure the NORA agenda is implemented. With stakeholder and partnership input, CDC is better positioned to address the toll of workplace injury, illness and death and is assured of having an appropriate research agenda. CDC continues to recruit new partners in occupational safety and health to further engage new stakeholders and increase the knowledge base.

GLOBAL HEALTH

INTERNATIONAL IMMUNIZATION

Together with Rotary International, World Health Organization (WHO) and UNICEF, CDC is one of the four leading partners in global polio eradication. The most important contribution of CDC to this partnership is deployment of its epidemiologists, public health experts, and scientists to WHO and UNICEF. CDC also provides funding through UNICEF for oral polio vaccine required for international mass immunization campaigns and a wide range of technical expertise and laboratory support for the polio eradication initiative. This includes staff support for disease surveillance at global, regional, and national levels and investigating outbreaks of polio, especially in areas within or bordering polio free zones. CDC provides state of the art virological surveillance expertise (genetic fingerprinting) to identify the strain of poliovirus involved and pinpoint its exact geographical origin. CDC also provides assistance in the development and monitoring of the 147 members of the global polio laboratory network, including funding short term and long term technical support in key countries. CDC collaborates with the WHO in conducting research that will facilitate development of post certification immunization and surveillance policies.

WHO, UNICEF, and CDC have prepared a five year strategic plan (2001-2005) for global measles control, mortality reduction, and regional elimination. The plan calls for a one half reduction in measles mortality by 2005 compared with 1999 levels. CDC is also a major partner with the American Red Cross, the International Federation of Red Cross and Red Crescent Societies, the Pan American Health Organization (PAHO), WHO, UNICEF, and the United Nations Foundation in reducing measles mortality in Africa, the region with the highest mortality burden. CDC deploys expert staff, procures measles vaccine, and provides technical assistance and operational support for a wide variety of surveillance, laboratory, and vaccination activities.

In 2004, CDC increased efforts to strengthen national immunization programs in priority countries. CDC serves as a key technical partner in the development of the WHO/UNICEF Global Immunization Vision and Strategies (GIVS) – a document outlining the 10 year strategic plan for strengthening national immunization systems. In addition, CDC is developing and implementing strategies and activities to assist priority countries and regions to better deliver immunization services to populations in need, and to strengthen data management and surveillance systems for vaccine preventable diseases.

OTHER INTERNATIONAL

CDC works with many other partners to implement programs and to provide guidance and technical support. These include the host government, foundations, international organizations, faith-based organizations and non-governmental organizations. CDC coordinates on various issues with the Department of State ranging from the

President's Emergency Plan for AIDS Relief (Emergency Plan) to building and facilities. CDC also provides technical assistance in support of numerous USAID projects and when there is a need for assistance in an emergency response, CDC works closely with the Office of U.S. Foreign Disaster Assistance.

In addition to the working relationships established individually with WHO, UNICEF, the American Red Cross and through the Measles Initiative, technical and programmatic experts also provide support to a growing malaria partnership. CDC also works with the World Bank, the UN Foundation, CARE International and many others on initiatives and projects.

TERRORISM

CDC's primary partners in developing national capacity for terrorism preparedness and emergency response are the public health departments of state, territorial and strategic metropolitan population centers.

In addition, CDC partners with federal agencies, academic institutions, and non-governmental organizations, such as Association of Public Health Laboratories (APHL), Food and Drug Administration (FDA), U.S. Army Medical Research Institute for Infectious Diseases (USAMRIID), National Association of County and City Health Officials (NACCHO), National Governors Association (NGA), National Emergency Management Association (NEMA), Infectious Disease Society of America (IDSA) and the Department of Veteran's Affairs (VA). In addition, CDC is partnering with business groups to insure that the private sector is also prepared to deal with public health emergencies.

EXHIBIT Z. DATA VERIFICATION AND VALIDATION

INFECTIOUS DISEASES

INFECTIOUS DISEASES CONTROL

Data is obtained from a variety of sources across CDC, including the National Notifiable Disease Surveillance System (NNDSS), the National Congenital Rubella Syndrome Registry (NCRSR), the Active Bacterial Core Surveillance (ABCs), Emerging Infections Programs, and the National Health Interview Survey (NHIS).

GROUP B STREPTOCOCCAL DISEASE SURVEILLANCE, PART OF THE EMERGING INFECTIONS PROGRAM'S ACTIVE BACTERIAL CORE SURVEILLANCE (ABCs)

In 1989, CDC initiated active surveillance for group B streptococcal (GBS) disease as part of the Active Bacterial Core Surveillance (ABCs) system, an active surveillance system for several pathogens that cause invasive disease. Surveillance was conducted in five geographic areas that were awarded contracts after a competitive request for proposals. In 1994, active surveillance for GBS disease was included as a core activity of the newly established Emerging Infections Program (EIP) network, a cooperative agreement program that addresses important public health issues related to infectious diseases. In 2003, the EIP network comprised 10 states; all participated in ABCs and conducted active surveillance for invasive GBS disease.

Specific objectives for GBS disease surveillance are to: 1) assess the impact of CDC prevention guidelines published in May 1996 and revised in August 2002, 2) determine the extent to which continuing cases of early-onset GBS disease are preventable through current prevention strategies, and 3) identify serotypes responsible for disease to guide vaccine development.

Data collection focuses on disease occurrence. State surveillance officers contact personnel in all microbiology laboratories that process bacterial cultures from sterile sites to find cases of GBS. Laboratory audits are also conducted semi-annually to detect possible under-reporting. Data are transmitted electronically from the EIPs to CDC's ABCs team on a monthly basis. Annual surveillance reports are made available on the Internet at the ABCs website (www.cdc.gov/abcs). Laboratory testing of isolates collected as part of surveillance is performed in reference laboratories. Electronic files containing results of laboratory testing of each state's isolates are fed back to that state on a monthly basis.

Routine laboratory audits to ensure the completeness of data collection represent a tremendous strength of the system. Each month, CDC staff review data and transmit potential errors to state personnel for evaluation. Performance standards for active surveillance have been established in each site to permit aggregation of data collected via somewhat different approaches. Detailed instructions for completion of case report forms ensure consistency across sites. State surveillance officers and CDC's ABCs team hold monthly conference calls to address logistical and technical aspects of the system and meet annually to review and update protocols, present special studies, and discuss innovations. Site visits are currently conducted on an as-needed basis.

Easy access to the data is provided through a website that includes the basic protocol and one-page yearly surveillance reports for each pathogen. Additional information on GBS is available on a website focused on that infection, with many materials targeted to pregnant women or healthcare providers and public health workers concerned with pregnant women (www.cdc.gov/groupbstrep).

The principal limitation of GBS disease surveillance through the ABCs is that it is not conducted throughout the U. S. Substantial geographic variation in the incidence of invasive GBS disease has been noted, and it is unclear whether states outside ABCs areas have experienced changes in the incidence of GBS disease that are comparable to those noted in the surveillance areas. One way of addressing this limitation is to increase the availability of ABCs methods and tools. Through the website and frequent publications, CDC is attempting to provide other state health departments with information that can help them assess whether the efforts involved in conducting invasive GBS disease surveillance, particularly for early-onset disease in infants <seven days, are feasible in their locales.

U.S. SENTINEL PROVIDER SURVEILLANCE FOR INFLUENZA

Established in 1982, the U.S. Sentinel Provider Influenza Surveillance Network is one of four primary sources of influenza surveillance data. Until 2002, the sentinel provider surveillance system was an active system of surveillance conducted from October through May. It has since been expanded to a year-round activity. Each week volunteer healthcare providers around the country report the total number of patients seen and the number of those patients with influenza-like illness by age group.

During the 1997-98 influenza season, 27 states and the District of Columbia elected to participate in a pilot program to upgrade the sentinel provider surveillance system. The pilot merged CDC's national sentinel surveillance system

and state-based systems into one integrated system based on common methodologies and standards. The pilot was successful and the modified system was retained, allowing the system to expand from approximately 200 enrolled providers during the 1996-97 influenza seasons to more than 1,900 providers enrolled from all 50 states and the District of Columbia during the 2003-04 season. A password protected Internet reporting and feedback system was developed and is central to the success of the system. States are responsible for establishing, recruiting, and maintaining state-based sentinel provider groups and for ensuring that data are collected and transmitted regularly to a central data repository at CDC, which makes data available to the State and CDC simultaneously. CDC is responsible for coordinating the system nationally, maintaining the reporting systems, processing and analyzing the data, and maintaining the Internet site. Efforts to improve the system are continuous.

Sentinel providers can report data via any of three methods: 1) Internet reporting, 2) touchtone phone reporting, or 3) facsimile transmission with manual entry of data. Programs developed by CDC integrate the three sources of data into a single database accessible via the password protected Internet site. Data are available in real time to each state coordinator. A summary of influenza activity is available to the general public each week.

CDC has undertaken a continuous process to simplify use of the system, clarify case definitions, and offer multiple options for input and access. With continuous updates and weekly summaries, the information is extremely timely and pertinent for decision making.

CDC epidemiologists analyze the data for outlying information and perform routine checks for coherence. State coordinators routinely check the timeliness of reporting and troubleshoot problems at the local level. Guidelines are provided to sentinel providers for optimal timing of specimen collection for virologic testing on certain patients. There is no way to ascertain that the data on influenza-like illness is free of error, but, as the number of participating sentinel providers increases, the potential consequences of errors decrease. Given that sentinel surveillance provides an index of current influenza activity, consistent reporting by a stable group of providers is imperative for data reliability. Increasing sentinel providers sites and sentinel providers participation in each state greatly increases the validity of the data.

HIV / AIDS, STD AND TB PREVENTION

CDC uses multiple data collection systems to monitor HIV trends and prevention programs. The HIV/AIDS Reporting System (HARS) collects case reports of HIV-infected persons in state and local health departments. AIDS case data are available from all states and territories using uniform name-based collection methods (no names or personal identifiers are sent to CDC; these are maintained only at the local level). Although the completeness of reporting of diagnosed AIDS cases varies by area and patient population, studies indicate that reporting in most areas is more than 85 percent complete. Reporting of AIDS deaths is estimated to be more than 90 percent complete. In contrast, HIV data collection systems vary between areas (e.g., name-based code, coded identifier, name-to-code data collection systems). CDC is conducting validation and evaluation studies of these systems to determine the quality of data generated by them. Currently, trends in HIV diagnoses for adults and adolescents are available only from 30 areas which have implemented name-based HIV case reporting (using methods similar to those for AIDS case reporting) since at least 1998.

The period of time between a diagnosis of HIV or AIDS and the arrival of a case report at CDC is called the "reporting delay" (40 percent of AIDS cases are reported to CDC within three months of diagnosis, 80 percent within one year). In order to provide the best estimates of trends in incidence, HIV and AIDS surveillance data are analyzed by the date of diagnosis and are mathematically adjusted in more recent periods to adjust for reporting delays and incomplete information on some cases. CDC requires a minimum of 18 months after the end of a calendar year to provide accurate estimates of trends for that year. For example, calendar year 2003 data will be available in the fall of 2005.

In addition to the HARS data, CDC funds supplemental surveillance systems to collect in depth information on HIV/AIDS cases and prevention programs. The Supplement to the HIV/AIDS Surveillance (SHAS) project collects interview information from persons >18 years of age with recently reported HIV/AIDS cases in 16 state/local health department jurisdictions. Information is collected on their sex and drug using behaviors, access to and adherence to care, and utilization of prevention interventions. The HIV Counseling and Testing System (CTS) collects information on the number of tests performed, demographic and other characteristics, test results, and utilization of post test counseling services in publicly-funded sites in all states.

Surveillance reports and in depth analyses of data from these systems are available upon request from CDC. In 2005, CDC will implement a new system, the "Morbidity Monitoring System."

STD incidence and prevalence data (hardcopy and electronic) undergo ongoing verification and validation procedures including quarterly reports back to project areas comparing reporting across all data sources, trend information, percentage unknowns for clinical fields, edit checks and updates, as well as constant communication via fax, phone, and e-mail with project staff. Pelvic Inflammatory Disease (PID) hospitalization data are collected by the National

Center for Health Statistics, and PID initial visits to physicians are collected through the National Diagnostic and Therapeutic Index by IMS America, Ltd. Additional feedback is provided to project areas via annual publications and reports.

Data on the prevalence of chlamydial infection in defined populations have been useful in monitoring disease burden and guiding screening programs. In particular, CDC monitors trends in prevalence among women enrolled in the U.S. Department of Labor National Job Training Program and among women screened for chlamydia attending family planning clinics. These programs provide crucial information on the prevalence of chlamydia in high-risk populations, i.e., young sexually active women.

Although these prevalence data are not entirely comparable because of differences in the performance characteristics of screening tests and variations in screening criteria, they provide important information on the continuing high burden of disease. The data also allow for chlamydia monitoring in multiple venues and populations that is critical to understanding the true burden of disease.

National Job Training Program participants, who are required to be screened for chlamydia at program entry, represent an important high-risk population CDC is trying to reach, sexually active women under age 25. Although CDC does not have activities targeted specifically to Job Training Program participants, CDC includes data provided by the U. S. Department of Labor because the data are an important component of assessing burden of disease. Continued expansion of chlamydia screening should lead to a continued reduction of the burden of disease among women, including National Job Training Program participants.

Accurate estimates of PID and tubal factor infertility from gonococcal and chlamydia infections are difficult to obtain. Definitive diagnosis of these conditions often requires complex surgical or other diagnostic tests. Most cases of PID are treated on the basis of interpretations of clinical findings, which vary among practitioners. In addition, the settings in which care is provided can vary considerably over time. For example, women with PID who would have been hospitalized in the 1980s may be treated in outpatient facilities today. Future declines in the incidence PID will hinge in part upon expansion of screening and treatment programs for chlamydia and gonorrhea, as well as expansion of health promotion efforts that increase both public and provider awareness.

Information on the percentage of TB patients reported in 2004 who complete TB treatment within 12 months will be available in June 2006. The last TB cases reported on December 31, 2004 will not have their 12-month treatment period completed until December 31, 2005. Then, six-nine months are needed to tabulate, complete, verify, and report the data. This information is obtained from the national TB Surveillance System. Information on the percentage of TB cases reported in 2004 with initial positive cultures and drug susceptibility results will be available by June 2005. This information is obtained from the national TB Surveillance System.

CDC recently revised the national reports for the data that addressed the following two measures: (1) increase the percentage of contacts of infectious cases who are placed on treatment for latent TB infection and complete a treatment regimen; and (2) increase the percentage of other high-risk infected persons who are placed on treatment for latent TB infection and complete a treatment regimen. For the first measure, the definition for contacts changed from contacts of "infectious cases" to "sputum smear-positive cases." The new system came on-line in CY 2000; the data for 1999 will not be representative because of the transition that occurred.

Information on the completion of treatment for latent TB infection for contacts of smear-positive cases that are started on treatment in 2004 will be available in mid-2006. Depending on the regimen used, it takes two-nine months to complete treatment. Therefore, some patients will not complete treatment until December 31, 2005. Approximately six-nine months are allowed to tabulate, complete, verify, and report the data. This information is obtained from the national Aggregate Reports for TB Program Evaluation.

Information on the percentage of complete reporting of surveillance data items for TB cases reported in 2004 will be available by June 2005. This information is obtained from the national TB Surveillance System.

TB morbidity data and related information submitted via the national TB Surveillance System are entered locally or at the state level into CDC-developed software which contains numerous data validation checks. Data received at CDC are reviewed to confirm their integrity and evaluate completeness. Routine data quality reports are generated to assess data completeness and identify inconsistencies. These reports are shared with the reporting areas and discussed during site visits.

Data submitted via the national Aggregate Reports for TB Program Evaluation are checked for accuracy and inconsistencies. Problems are resolved by CDC staff working with state and local TB program staff. During regular visits to state, local, and territorial health departments, CDC staff review TB registers and other records and data systems and compare records for verification and accuracy. At the end of each year, data are again reviewed before data and counts are finalized and published.

IMMUNIZATION

CASES OF DISEASES

The statistics on the number of cases of disease in the U. S. are collected and compiled from reports sent by state health departments to the National Notifiable Diseases Surveillance System (NNDSS), which is operated by CDC in collaboration with the Council of State and Territorial Epidemiologists (CSTE). Data is also obtained from the National Congenital Rubella Syndrome Registry (NCRSR), the Active Bacterial Core Surveillance (ABCs), Emerging Infections Programs, and the National Health Interview Survey (NHIS).

IMMUNIZATION COVERAGE RATES

The National Immunization Survey (NIS) is used to assess progress towards the goals for children. NIS data provide current, population based, state and local estimates of vaccination coverage produced by a standard methodology. Quarterly data are collected via household interviews in 50 states, the District of Columbia, and 27 urban areas. Interviews are conducted by telephone with randomly selected households. Each quarter, CDC calculates estimates of vaccination coverage levels and makes valid comparisons of state efforts to deliver vaccination services. CDC uses NIS data to evaluate progress towards national vaccination goals and to identify states with the highest and lowest immunization rates.

To ensure the accuracy and precision of coverage estimates, immunization data for surveyed children are also collected through a mail survey of their pediatricians, family physicians, and other healthcare providers. The parents and guardians of NIS eligible children are asked during the telephone interview for consent to contact children's medical providers. Types of immunizations, dates of administration, and additional data about facility characteristics are requested from immunization providers identified during the telephone survey of households. NIS estimates of vaccination coverage therefore reflect a comparison of information provided by both immunization providers and households.

For adult non institutionalized populations, data is collected through the National Health Interview Survey (NHIS). The National Health Interview Survey (NHIS) is the principal source of information on the health of the civilian non-institutionalized population of the U. S. and is one of the major data collection programs of CDC. The National Nursing Home Survey (NNHS), is the source for institutionalized populations.

VACCINE SAFETY DATALINK

The Vaccine Safety Datalink (VSD) involves partnerships with seven large health maintenance organizations (HMOs) to continually monitor vaccine safety. VSD is an example of a large linked database (LLDB) and includes information on more than six million people.

NATIONAL IMMUNIZATION SURVEY

The National Immunization Survey (NIS) has been conducted annually since 1994 to determine the vaccination coverage rates of children 19-35 months of age.

The NIS was established to provide an ongoing consistent data set for analyzing vaccination levels on young children in the U. S. NIS data provide current, population-based, national, state and local estimates of vaccination coverage produced by a standard methodology. Quarterly data are collected from household interviews in 50 states, the District of Columbia, and 27 urban areas. Interviews are conducted by telephone with randomly selected households. Each quarter, CDC calculates estimates of vaccination coverage rates and makes valid comparisons of state efforts to deliver vaccination services. CDC uses NIS data to evaluate progress towards national vaccination goals and to identify states with the highest and lowest immunization rates.

To validate the phone responses, immunization data for surveyed children are also collected through a mail survey of their pediatricians, family physicians, and other healthcare providers. The parents and guardians of NIS-eligible children are asked during the telephone interview for consent to contact their children's medical providers. Types of immunizations, dates of administration, and additional data about facility characteristics are requested from immunization providers identified during the telephone survey of households. As a result, NIS estimates of vaccination coverage reflect a comparison of information provided by both immunization providers and households.

HEALTH PROMOTION

CHRONIC DISEASE PREVENTION, HEALTH PROMOTION AND GENOMICS

BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM

In 1984, CDC initiated the Behavioral Risk Factor Surveillance System (BRFSS), a unique, state-based surveillance system designed to collect prevalence data on behavioral risks and conditions that affect health. States conduct monthly telephone surveys using a standardized questionnaire to determine the distribution of behavioral risk factors. Survey responses are forwarded to CDC, where the data are aggregated and published at year's end. The BRFSS provides flexible, timely, and ongoing data collection that allows for state-to-state and state-to-nation comparisons. Participating states use data derived from the BRFSS to identify demographic variations in health-related behaviors, target services, address emerging and critical health issues, propose legislation for health initiatives, and measure progress toward state and national health objectives. The system's broad network of information gathering also enables states to evaluate their disease prevention and health promotion efforts.

The BRFSS survey instrument is a three-part questionnaire developed jointly by CDC and the states:

- Core component: The fixed core is a standard set of questions asked by all states on demographic characteristics and behaviors that affect health (e.g., tobacco use, alcohol consumption). The rotating core includes two sets of questions, each asked in alternating years by all states that address different topics. The emerging core consists of up to five questions that typically focus on late-breaking issues. These questions are added to the core for one year and evaluated at year's end to determine their potential value in future surveys.
- Optional CDC modules: These are sets of questions on specific topics (e.g., smokeless tobacco use, arthritis) that states can opt to include in their questionnaires.
- State-added questions: These questions are developed or acquired by participating states and added to their questionnaires. State-added questions are not edited or evaluated by CDC.

Each year, states and CDC agree on the content of the core components and optional modules. For ease of comparability and use, many of the questions are taken from established national surveys. More than 30 validity and reliability studies attest to the quality and validity of data derived from the BRFSS.

YOUTH RISK BEHAVIOR SURVEILLANCE SYSTEM

CDC established the Youth Risk Behavior Surveillance System (YRBSS) in 1990. One of the components is a national school-based survey that was first conducted in 1990 and has been repeated biennially since 1991. The national Youth Risk Behavior Survey (YRBS) measures six categories of priority health risk behaviors that contribute to the leading causes of mortality and morbidity among youth and adults in the U. S.: 1) behaviors that may lead to violence and unintentional injuries; 2) tobacco use; 3) alcohol and other drug use; 4) sexual behaviors that contribute to HIV infection, other sexually transmitted diseases and unintended pregnancy; 5) unhealthy dietary behaviors; and 6) inadequate physical activity.

The YRBS is administered in the spring to nationally representative samples of students in grades nine-12 attending both public and private schools. Professional data collectors, trained specifically for the YRBS, are used as field staff to ensure standard administration procedures. The YRBSS uses a three-stage cluster sample to select schools and classes of students within schools. African-American and Hispanic students are oversampled to provide accurate estimates for these subgroups in each survey cycle. By combining data from multiple survey cycles it is also possible to obtain accurate estimates for Asian and Native American youth. The sample size totals approximately 14,000 students per survey. School response rates average 76 percent; student response rates average 88 percent.

The YRBS questionnaire is designed for self-administration with a computer-scannable booklet. The questionnaire has been modified as needed to address emerging public health problems. A reliability study of the questionnaire conducted in 2000 demonstrated that students reported health risk behaviors reliably over time. Psychometric work has demonstrated that the questionnaire yields accurate and high-quality data. Standardized data editing and cleaning procedures improve data accuracy and consistency. Data are released within 12 months of data collection and are made available to the public via the Internet.

HEART DISEASE & STROKE

CDC will evaluate stroke registry capacity via annual state reports, deaths from heart disease and stroke via death certificate data from states, and uncontrolled high blood pressure data from HRSA.

EARLY DETECTION OF BREAST AND CERVICAL CANCER

CDC uses the Minimum Data Elements (MDEs) to report on all GPRA measures. States, territories, and tribal organizations (NBCCEDP grantees) submit MDEs electronically twice a year (October 15 and April 15) to a data management contractor, who analyzes the data and submits analysis data to CDC in July and February. NBCCEDP grantees are provided 9.5 months after the initial screening date to gather diagnostic and treatment information for submission and an additional three and a half months are needed for the contractor to prepare the analysis. All data collected and submitted by NBCCEDP grantees have indicators to assess completeness. Data are also assessed against established clinical standards.

NATIONAL PROGRAM OF CANCER REGISTRIES

Participating states are expected to collect information on at least 95 percent of cancer cases diagnosed or treated in their state each year. States report identified cancer case data annually to CDC's NPCR-Cancer Surveillance System. NPCR-funded states incorporate NAACCR standards for data quality and format in reporting their cancer incidence data. CDC receives regular reports from each state that summarize progress of completeness, timeliness, and quality of registry data. NPCR staff also prepare annual internal evaluations of program progress.

DIABETES PREVENTION AND CONTROL PROGRAMS

CDC verifies performance through quarterly state reports and periodic site visits. For efforts in American Indian/Alaska Native populations, data are verified via program reports and documentation of support. The BRFSS collects data on receipt of annual eye and foot exams in persons with diabetes.

TOBACCO USE PREVENTION

CDC monitors cigarette use among youth and reports performance on a biennial basis using the Youth Risk Behavior Survey (YRBS), which is a component of the YRBSS (see Appendix A.2). Three additional surveys, the National Household Survey on Drug Abuse (NHSDA) the Monitoring The Future (MTF) Survey, and the National Youth Tobacco Survey (NYTS), provide complementary data for examining trends and understanding youth-related tobacco issues. The NHSDA is conducted annually by SAMHSA; the MTF is conducted annually by the University of Michigan's Institute for Social Research; and the NYTS is currently conducted by the American Legacy Foundation, but will transfer to CDC in 2004.

NUTRITION AND PHYSICAL ACTIVITY PROGRAM TO PREVENT OBESITY AND OTHER CHRONIC DISEASES

CDC plans to collect and evaluate state data on nutrition and physical activity programs via annual state program reports, semi-annual progress reports, site visit reports, and a program evaluation database.

ARTHRITIS PROGRAMS

CDC collects and evaluates data on state-based arthritis programs via annual state program reports and site visits.

ORAL HEALTH PROGRAMS

CDC is continuing to enhance the National Oral Health Surveillance System (NOHSS). Launched in January 2001, NOHSS is designed to help public health programs monitor the burden of oral disease, use of the oral health care delivery system, and the status of community water fluoridation on both a state and national level. NOHSS currently includes data from 50 states and five data sources—the Behavioral Risk Factor Surveillance System (BRFSS), National Health and Nutrition Examination Survey (NHANES) III, the National Health Interview Survey (NHIS), the Water Fluoridation Reporting System, and the Association of State and Territorial Dental Directors' (ASTDD) annual Synopses of State and Territorial Dental Programs.

HIV PREVENTION AMONG SCHOOL-AGED YOUTH

Data is collected on a biennial basis (during odd-numbered years) through CDC's YRBSS, a system designed to focus attention on priority behaviors among youth that are associated with the most important health problems (see Appendix B). The YRBSS was developed in partnership with federal agencies, state departments of education and health, scientific experts, and survey research specialists. The YRBSS includes separate national, state, and local school-based surveys of high school students. A recent study provides evidence that this adolescent survey has good reliability in measuring health behavior. Baseline data from the 1995 YRBSS are used because: 1) they were the most recent data available when the original measures were created, and 2) they will allow a more accurate illustration of trends in sexual behaviors over time.

PREVENTION RESEARCH CENTERS

Data are available from grantee progress reports and will be verified through site visits and publications. CDC program consultants validate information received through site visits and telephone consultations. No data lags are expected.

BIRTH DEFECTS, DEVELOPMENTAL DISABILITIES, DISABILITY AND HEALTH

For the goal to prevent birth defects and developmental disabilities, the performance measures use data from CDC's Behavioral Risk Factor Surveillance System (measure 1), the National Birth Defects Prevention Network (measures 2 and 3) and soon to be established developmental disabilities data coordinating center (measure 4).

For the goal to improve the health and quality of life of Americans with disabilities, the performance measures use data from the Directors of Speech and Hearing Programs for State Health and Welfare Agencies, as well as a count of specific programs implemented at the state level.

HEALTH INFORMATION AND SERVICE

HEALTH STATISTICS

Performance goals for health statistics are primarily oriented toward measures of the output of CDC's health statistics data systems. Information for monitoring these goals is available in most instances from the internal administrative management systems of CDC. These include monitoring of routine reports from contractors on the performance of field operations of surveys (such as the response rate for NHANES), monitoring of the publication dates of CDC data reports (in order to monitor timeliness), and monitoring of postings on CDC's Internet site (to monitor Internet accessibility).

NATIONAL HEALTH AND NUTRITION EXAMINATION SURVEY

The National Health and Nutrition Examination Survey (NHANES) is a program of studies to assess the health and nutritional status of adults and children in the U. S. Started in the early 1960s, NHANES is the only national source of objectively measured health data capable of providing accurate estimates of both diagnosed and undiagnosed medical conditions in the population.

Findings from the survey are essential for determining rates of major diseases and health conditions and for developing public health policies and prevention interventions. The survey screens 15,000 households per year and selects 3,500. From this sample, 5,000 persons are interviewed and examined annually. Samples are recruited from 15 counties or clusters of counties each year. Samples comprise sufficient numbers to provide reliable estimates by gender and age group for non-Hispanic whites, Mexican Americans, and African Americans.

Data are collected via health interview, physical examination, and clinical and laboratory tests. Interviews are conducted in respondents' homes. Physical examinations are performed in specially designed mobile examination centers that travel to survey locations throughout the country.

These centers allow for the collection of data on chronic conditions, nutritional status, medical risk factors, dental health, vision, illicit drug use, blood lead levels, food safety, and other factors that are not possible to assess by use of interviews alone. The medical team consists of a physician, dentist, medical and health technicians, and dietary and health interviewers. Trained bilingual staff conducts the household interviews. An advanced computer system using high-end servers, desktop PCs, and wide-area networking is used to collect and process all NHANES data, nearly eliminating the need for paper forms and manual coding operations. Household interviewers use notebook computers with electronic pens for data collection in the field. Data collected in the mobile examination centers are automatically transmitted via a frame relay network into central databases. Survey information is available to CDC within 24 hours of collection.

Information from NHANES is disseminated through an extensive series of publications and articles in scientific and technical journals. To improve CDC's timeliness, survey data is also available on CD-ROM and posted on the internet. The computerized system has already substantially improved access to the data from the field.

A comprehensive quality assurance program is instituted before data collection begins, with appropriate training that requires significant practice time for the health examiners and interviewers. Training focuses on hands-on experience rather than didactic methods. During data collection, health examiners and survey staff meet regularly to discuss operations, updates, and problems. Staff members receive additional training as needed.

NHANES relies on both passive and active monitoring systems for operational and content-related quality control. Passive quality control uses automated computer procedures for detecting data anomalies. After careful analysis, appropriate activities can be undertaken to resolve any data collection issues. Active quality control relies on

examiner feedback to identify and evaluate problems and select remedies. NHANES primarily relies on physical measurements from well-established biomedical procedures. In most instances, these measurements represent the gold standard data against which self-reported data might be validated for other subjective data collection modalities. New technologies under consideration are evaluated to determine if they provide valid estimates of the condition, risk factor, or measurement for which they are being used. The evaluation might include a scientific literature review, expert workshop, or validity study.

NATIONAL HEALTH INTERVIEW SURVEY

The National Health Interview Survey (NHIS) is the principal source of information on the health of the civilian, non-institutionalized population of the U. S. The purpose of the NHIS is to monitor the health of the U.S. population through the collection and analysis of data on a broad range of health topics. The strength of this survey is its ability to display health characteristics by many demographic and socioeconomic factors.

NHIS data are used widely throughout HHS to monitor trends in illness and disability and to track progress toward achieving national health objectives. The data are also used by the public health research community for epidemiologic and policy analysis.

The NHIS is a cross-sectional household interview survey. Sampling and interviewing are continuous throughout each year. Households chosen for interviews are a probability sample representative of the target population. NHIS data are collected annually from approximately 43,000 households including about 106,000 persons (when fully funded). Survey participation is voluntary, and the confidentiality of responses is ensured. The annual response rate is >90 percent of eligible households in the sample.

The NHIS has three modules:

- The basic module remains largely unchanged from year to year and allows for trend analysis. Data from more than one year can also be pooled to increase the sample size for analytic purposes. The basic module contains a family core, a sample adult core, and a child core through which data are collected on the family unit and from one randomly selected adult and child.
- Periodic modules collect more detailed information on some of the topics included in the basic module.
- Topical modules respond to new data needs as they arise.

Data are collected through a personal household interview conducted by staff employed and trained by the U.S. Bureau of the Census according to procedures delineated by CDC. Data are reviewed and analyzed extensively to ensure their validity and reliability. The survey sample is designed to yield estimates that are representative and that have acceptably small variations.

Before the actual survey, cognitive testing is performed by CDC's Questionnaire Design Research laboratory, and pretests are conducted in the field. Once collected, data are carefully edited, checked, and compared to data from earlier surveys and/or independent sources. Staff members calculate descriptive statistics and perform in-depth analyses, which result in feedback on the analytic usefulness of the data.

NATIONAL HOSPITAL DISCHARGE SURVEY

The National Hospital Discharge Survey (NHDS), conducted annually since 1965, is a national probability survey designed to meet the need for information on characteristics of inpatients discharged from non-federal, short-stay hospitals in the U. S. The NHDS collects data from a sample of approximately 300,000 inpatient records acquired from a national sample of about 500 hospitals. The NHDS provides national and regional estimates of U.S. inpatient hospital utilization by the demographic characteristics of patients discharged, conditions diagnosed, and surgical and non-surgical procedures performed. Approximately 95 percent of eligible sample hospitals respond to the survey.

The NHDS uses two data collection methods: 1) a manual system in which hospital staff or staff of the U.S. Bureau of the Census abstract data from medical records, and 2) an automated system in which CDC purchases machine-readable medical record data from commercial organizations, state data systems, hospitals, or hospital associations. Approximately 40 percent of hospitals provide data through the automated system.

An ongoing quality control program helps to ensure the accuracy of NHDS data. NHDS data have been found to be a good reflection of information found in medical records. What is not known is the degree to which medical record information reflects actual performance.

NATIONAL VITAL STATISTICS SYSTEM

Vital statistics are often the most complete and continuous information available to public health officials at the national, state, and local levels. The National Vital Statistics System is responsible for the nation's official vital

statistics. The registration of vital events – births, deaths, marriages, divorces, fetal deaths – is a state function, and vital statistics are provided through state-based registration systems. Since 1902, the federal government has obtained use of the records for statistical purposes through cooperative arrangements with the responsible agencies in each state. Standard forms for the collection of data and model procedures for the uniform registration of events are developed and recommended for state use through cooperative activities of the states and CDC. CDC also provides training and instructional materials to the states as part of ongoing technical assistance.

The purpose of collecting the data is to monitor trends over time through vital life events. Vital records and reports originate with private citizens, such as the family affected by the events, physicians, or funeral directors. By law, birth registration is the direct responsibility of the hospital of birth or the attendant at the birth. In the absence of an attendant, the parents of the child are responsible for registering the birth. Although procedures vary from hospital to hospital, personal information is usually obtained from the mother; medical information may be obtained from the chart or from a worksheet completed by the birth attendant. Reporting requirements vary from state to state; in general, the completed certificate must be filed with the state or local registrar within 10 days of birth. Published data represent all counties and places with a population of 10,000 or more. Electronic files include data for states, counties, large cities (population of 100,000 or more), and metropolitan statistical areas.

By law, death registration is the direct responsibility of the funeral director or person acting as such. The funeral director obtains the data required, other than the cause of death, from the decedent's family or other informant. The attending physician provides the best medical opinion about the cause and manner of death. Then, this information is coded by the state or CDC according to uniform codes. Demographic information is also recorded. If no physician was in attendance or if the death was due to other than natural causes, the medical examiner or coroner investigates the death and provides the cause and manner. Reporting requirements for death vary, but in general the completed certificate must be filed within three to five days of the death. Published data include all counties and places with a population of 10,000 or more. Electronic files include data for states, counties, large cities (population of 100,000 or more), and metropolitan statistical areas.

Fetal deaths are also reported through the National Vital Statistics System. All fetal deaths of 20 weeks or more gestation that occur in the U. S. are recorded. A linked birth/infant death file allows for the analysis of demographic and health characteristics from certificates of live births in combination with causes of death and other data from death certificates of infants who died before their first year of life.

The linked file set includes information on all the infants who died in the U. S. each year, as well as information on all live births. An additional file includes information on death records not linked to birth certificates. The match rate is about 97-98 percent. Data are organized by calendar year.

Provisional and final estimates of the number of marriages and divorces are obtained from each state able to provide these figures. Since data are not available from all states, national divorce rates are not produced. Detailed characteristics of marriages and divorces have not been available since 1996.

Vital statistics data are collected using uniform procedures and are accurate and consistent. The data are reported as soon as they are analyzed by CDC staff. Monthly provisional numbers and rates are published in the *National Vital Statistics Reports*. These figures are based on approximate counts of the number of events that occurred in a given state; an estimation procedure is used to convert these occurrence estimates into state-specific estimates of the number and rate of resident events. Preliminary data collected through the National Vital Statistics System are made available to the public within 10 months after the end of the collection year. Data are presented for a 12-month period and are published semi-annually in the *National Vital Statistics Reports*. Final data are released about 12 months after collection via *National Vital Statistics Reports*, public use data tapes, CD-ROM, Series Reports, the Internet, and journal articles. Use of electronic products have greatly increased the accessibility of the data and reduced the costs to researchers and other users.

The data collected through the National Vital Statistics System represent all registered vital events in the U. S. and adequately represent the true rates of events. To record more accurately birth and death information, new birth and death certificates have been designed through a collaborative effort with states, researchers, and other interested parties. The revised certificates reflect changing data needs and emerging public health applications; they were implemented in 2003.

ENVIRONMENTAL HEALTH AND INJURY

ENVIRONMENTAL HEALTH

CHILDHOOD LEAD POISONING

The National Childhood Lead Poisoning Prevention Program is supporting the development of web-based tracking systems, which should result in less duplication of efforts. In addition, it is supporting increased reporting from

laboratories electronically, resulting in fewer errors introduced in data during data entry. The tracking system CDC is developing for lead will have data quality checks built in so the user can check data quality periodically. In addition, quality checks are performed at CDC when states submit their surveillance data to CDC. Lead branch epidemiologists are developing guidelines for analyzing surveillance data to ensure appropriate application of statistical and epidemiologic methods.

ASTHMA

Data verification is based on required reporting by grantees. CDC project officers will verify that states are fulfilling the requirements of cooperative agreements through routine monitoring of the grants process. CDC epidemiologists will review all statistical and surveillance data to ensure appropriate application of statistical and epidemiologic methods.

ENVIRONMENTAL HEALTH LABORATORY/BIOMONITORING

All analytical methods developed must be certified under the Clinical Laboratory Improvements Act of 1988 (CLIA). Data systems at CDC's Environmental Health Laboratory monitor laboratory performance under CLIA. CDC also conducts quality assurance activities internally to confirm results and ensure their validity. CLIA-approved methods are used to analyze levels of environmental chemicals published in the *National Report on Human Exposure to Environmental Chemicals* that are measured in specimens obtained from the *National Health and Nutrition Examination Survey* (NHANES). The use of CLIA-approved methods is verified by senior staff as well as by internal quality assurance officers. The sample size and control mechanisms for the *Report* have been established as part of NHANES.

NEWBORN SCREENING QUALITY ASSURANCE PROGRAM (NSQAP)

All data reported to participating laboratories by NSQAP and entered into data files for analysis are verified and cross-checked against the reported data for verification by a second person. The expected values for distributed specimens are verified by multiple assays and cross-checked for accuracy. Each participating laboratory has an assigned code number. Technical reports to participants include a data-verification page that contains actual data received and recorded by the NSQAP for checking by the participant if a question arises. All data are analyzed for outlier values, and these outliers are verified for actual reports by crosschecks. Computer data bases are maintained by laboratory code number so that any questioned reports by a participant can be verified.

CHOLESTEROL REFERENCE METHOD LABORATORY NETWORK PROGRAM

CDC reference methods have been recognized by the National Cholesterol Education Program as the accuracy base for measuring lipids and lipoproteins. Specifically, the reference methods for measuring cholesterol and triglyceride are traceable to higher-order methods at the National Institute for Standards and Technology (NIST). CDC and NIST both assign values to certified reference materials provided by NIST; thus, regular comparisons are performed and the bias between the CDC and NIST methods is well characterized. High-density lipoprotein cholesterol and low-density lipoprotein cholesterol are not homogeneous analytes; therefore, the CDC reference methods are recognized by NCEP as the highest-order methods available (NIST does not have a primary reference method for either of these analytes). Thus, CDC serves as the final accuracy point for these analytes. CDC has maintained careful documentation of quality assurance performed in every run over the course of many years and is able to document stability of the methods over time. CRMLN laboratory measurements are traceable to CDC through regular bimonthly surveillance of members' analytical methods. Member laboratories are required to meet stringent performance guidelines before they can certify manufacturers or clinical laboratories. If these requirements are not met, the CRMLN laboratory must take remedial action and demonstrate performance within the required guidelines before they can perform certification activities.

OCCUPATIONAL SAFETY AND HEALTH

Information will be reported through the Project Planning System of CDC's Integrated Resources Information System (IRIS). CDC will review all data for accuracy. Baseline data and data for subsequent years are collected in the same format to ensure accurate comparisons. Partnering efforts have increased the ability to track resources outside the organization.

GLOBAL HEALTH

The global measles data source is the World Health Organization (WHO) and the data source for measles cases in the Americas is the Pan American Health Organization (PAHO). Data is obtained from each country through an established, systematic surveillance data/reporting mechanism similar to how CDC gets data from the states.

The World Health Organization provides the polio case data based on reports submitted by countries.

TERRORISM

CONTROL, CONTAINMENT AND RECOVERY: THE SELECT AGENT PROGRAM

Entities that are required to register as defined by 42 CFR 73 must submit an application (CDC Form 0.1319) to CDC's Select Agent (SA) Program. Receipt and processing of applications and all documents (including inspection reports) utilized by the CDC Select Agent Program are controlled in accordance with locally approved procedures, as well as applicable Health and Human Services (HHS), CDC, and other regulatory guidance. An Electronic Document Management System (EDMS) is used to capture, index, and record the location of each document and to provide data necessary for rapid retrieval and review of the document.

Data from the application forms submitted from the public to the CDC Select Agent Program are manually entered into a database. The CDC Select Agent Program database is a Visual Basic application running on a Microsoft SQL server database that provides an interface for data entry and reporting capabilities. After CDC's Select Agent Program determines that the entity has met all safety, security, and record-keeping requirements, it is issued a registration certificate that is valid for a two to three year period. The dates of registration are captured in the SQL database. Entities that wish to register for select agents or toxins are inspected and are issued a report that cites any deficiencies noted during the inspection event. Dates of inspection (and, if appropriate dates that the entity has addressed all deficiencies satisfactorily) are entered into the SQL database.

PROGRAM EFFICIENCY

CDC has maintained a management information system on a Secure Data Network (SDN) for approximately one year called the SLPP-MIS System. This system is used to receive, process, monitor, and evaluate cooperative agreements of over \$900 million per year for 62 grantees. These funds are used to establish critical systems to prepare for and respond to terrorism, outbreaks of infectious diseases, and other public health threats and emergencies. Use of the SLPP-MIS System for progress reports, submission of applications and budgets is required in order for the grantees to receive these funds. There is also an internal tracking system component of SLPP-MIS called Enhanced Project Management (EPM) that is utilized by each of the CDC Project Officers, as well as Senior Staff, to track and maintain project issues, comments, progress, and provide reporting functionality on each of the 62 grantees.

EXHIBIT AA. PERFORMANCE MEASUREMENT LINKAGES

COST ACCOUNTING

CDC incorporates elements of full and marginal costing in the FY 2006 Congressional Justification. These elements are based on cost accounting principles, and can be used to inform budget decisions.

CDC conducted full cost exercises in the FY 2005 Annual Performance Plan and Report and FY 2006 Congressional Justification. The full cost of a program includes both direct and indirect costs. These costs are allocated to each of the agency's GPRA goals and measures. Full cost information provides the agency with a better understanding of the total resources applied to a particular goal or measure, and an analysis of the costs associated with the achievement of specific performance results. Please refer to Exhibit V (Summary of Full Costs) for additional information.

CDC's marginal costing methodology was piloted with the TB program. The marginal costing methodology relies upon the full costing methodology. The marginal costing methodology provides information relating to the marginal cost required to achieve a long-term performance goal. This information will inform policy and budget decisions and help CDC decision-makers to weigh the benefits of investing in one program versus another.

INFORMATION TECHNOLOGY PLANNING

The accurate reporting of performance data increasingly relies on technology. Obtaining reliable information is invaluable to CDC, as well as to public health programs at local, state, and national levels. Planning for technology needs, and associated investments, can be as critical as planning for public health events. Data systems need to produce information of sufficient quality and precision to detect relatively small changes in performance. Information technology (IT) investments may be required for larger sample sizes for surveys, new technologies that improve data quality or new systems that automate the collection and analysis of data.

CDC has implemented the requirements under the Clinger-Cohen Act of 1996 (CCA) for IT capital investment planning, monitoring, and performance measurement. The Information Technology Investment Review Board (ITIRB) process has been established and is a component of CDC's budget planning process. Major IT investments associated with budget initiatives required the development of a Capital Asset Plan and Business Case (Exhibit 300) as part of the submission. Also, in compliance with CCA, CDC has developed several components of the agency's information technology architecture, such as certain health data standards, networking and telecommunications architecture, information security, and the majority of the agency's administrative procedures. More extensive work on other core business processes, information flows, and process and data models is ongoing.

Several of CDC's performance measures are reflective of IT planning. Many of these are efficiency measures and were developed in response to OMB Program Assessment Rating Tool (PART) reviews. Examples include:

- The Chronic Disease Prevention, Health Promotion, and Genomics efficiency measure states: "Increase the number of Web-based management information systems resulting in savings of program staff time." This measure defines the number of management information systems within divisions that project officers use to provide more efficient program consulting to recipients.
- The Injury Prevention and Control efficiency measure states: "Through the implementation of Web-based systems for state and territorial agencies, decrease the time between the submission of an application and the receipt of funds for injury prevention and control efforts." Efficiencies are created because applications are received and processed more quickly. The workforce's time savings is realized by retrieving and summarizing grantee information faster and better than what can be collected otherwise and by providing for more efficient means of tracking and monitoring the status of submissions.
- The Terrorism efficiency measure states: "Fully automate the application, workplan and semi-annual reporting for cooperative agreement grantees to achieve greater program efficiencies." This measure addresses a system that automates the application process for grantees. Benefits of the system and new supporting processes are expected to improve timeliness of applications, ease of processing and production for review as well as elimination of paper processing. Additionally, development of the system addresses e-government provisions of the President's Management Agenda (PMA).

CAPITAL PLANNING: HUMAN CAPITAL

The strategic management of human capital is a priority for CDC. Initiatives include reducing layering, eliminating administrative positions through consolidation, further improving the supervisory ratio, and supporting the transition of CDC's workforce toward providing more frontline public health functions.

The Occupational Safety and Health efficiency measure is reflective of human capital planning. This measure states, "Determine future human capital resources needed to support programmatic strategic goals, focusing on workforce development/training and succession planning." Through this measure, CDC will strive to meet the human capital goals of the PMA, which calls for a reduction in layers of government, a reduction in the number of managers in each agency, and the ability to provide employee development and succession planning to enhance the work environment and provide future leadership.

In addition, CDC and ATSDR have addressed the issue of administrative redundancy through an administrative merger with CDC's National Center for Environmental Health (NCEH). NCEH and ATSDR now share a common NCEH/ATSDR Office of the Director. The consolidation became effective January 2, 2004, with the publication of an official announcement in the Federal Register.

CAPITAL PLANNING: IMPROVED FINANCIAL MANAGEMENT

CDC will continue to pursue an aggressive strategy to upgrade and improve fiscal management activities to provide timely, accurate, and pertinent information. CDC's impeccable scientific integrity and excellent record of fiscal stewardship and accountability are integrally related to provide the best programmatic and performance results.

CDC was selected to be the first HHS operating division to fully implement the Unified Financial Management System (UFMS). Implementation of this state-of-the-art financial system is underway. With the successful completion of phases 1 and 2, the General Ledger, Accounting For Pay System (AFPS), and Grants Processing modules are in place. The General Ledger includes CDC's overall accounting "books." Implementation of AFPS aligns CDC's method of payroll accounting with a department-wide standardized process. With Grants Processing, CDC will process two critical business functions – representing over 55 percent of its dollars and transactions – in UFMS. Full UFMS implementation is planned for April 2005.

PROGRAM EVALUATION

CDC continues to work diligently in the area of program evaluation, and this work has spanned the organization to include virtually every program across CDC.

Since PART evaluations began in the FY 2004 budget process, 12 CDC programs have been reviewed and evaluated including: 317 Immunization Program, Breast and Cervical Cancer, Diabetes, Domestic HIV/AIDS Prevention, HAN, ATSDR, State and Local Preparedness, Buildings and Facilities, Epidemic Services and Response, Occupational Safety and Health, Infectious Diseases, and Sexually Transmitted Diseases/Tuberculosis. The programs reviewed by PART have developed outcome-oriented and efficiency performance measures, and have seen improvements in strategy, program management and results. Please refer to the PMA section of this document for additional details about CDC's activities and accomplishments in these areas.

EXHIBIT BB. FY 2004-2005 ONE-PAGE PART SUMMARIES

Program: 317 Immunization Program

Rating: Adequate

Agency: Department of Health and Human Services

Program Type: Competitive Grant

Bureau: Centers for Disease Control and Prevention

Last Assessed: 1 year ago

<i>Key Performance Measures from Latest PART</i>	<i>Year</i>	<i>Target</i>	<i>Actual</i>
Long-term Measure: Number of cases of vaccine-preventable diseases in the United States as measured by cases of polio, rubella, measles, congenital rubella, mumps and tetanus.	2001	<150	<183
	2005	50	
	2006	50	
	2010	0	
Annual Measure: Percentage of children 19-35 months of age who receive recommended vaccines every year.	2001	90%	>=90%, Var 76%
	2004	90%	
	2005	90%	
	2006	90%	
Annual Measure: Number of polio cases worldwide.	2001	1500	483
	2002	500	1918
	2003	200	784
	2006	0	

Recommended Follow-up Actions from Latest PART **Status**

Will continue a comprehensive evaluation of the program and will work with grantees to better measure outcomes and allocate resources based on more clear criteria. Action taken, but not completed

Will review administrative functions to determine whether improvements in program operations and efficiency can be made. Action taken, but not completed

Update on Follow-up Actions:

The 2006 Budget includes a \$20 million increase for state grants for influenza immunizations and \$30 million to increase the supply of influenza vaccine. The 2006 Budget also includes a legislative proposal to make it easier for underinsured children who are eligible for the CDC Vaccines for Children program to receive immunizations in public health clinics. The legislative proposal will expand the VFC program and result in \$100 million in savings to the 317 discretionary childhood immunization program. The global polio measure will be tracked by the global immunization program, which will be assessed separately in the future, and not by the 317 immunization program.

Program Funding Level (in millions of dollars)

<u>2004 Actual</u>	<u>2005 Estimate</u>	<u>2006 Estimate</u>
469	516	429

Program: *Chronic Disease - Breast and Cervical Cancer*

Agency: *Department of Health and Human Services*

Bureau: *Centers for Disease Control and Prevention*

Rating: *Adequate*

Program Type: *Competitive Grant*

Last Assessed: *1 year ago*

<i>Key Performance Measures from Latest PART</i>	<i>Year</i>	<i>Target</i>	<i>Actual</i>
Annual Measure: Percentage of all newly enrolled women who have not received a Pap test within the past five years.	2001		0.229
	2004	22.5%	
	2005	25%	
	2006	25%	
Annual Measure: Percentage of women with breast cancer and cervical cancer who start treatment within 60 days of diagnosis.	2000		94%/88%
	2001		93.1%/88.5%
	2004	95%/92%	
	2006	95.5%/92.5%	
Long-term Measure: Measure Under Development			

Recommended Follow-up Actions

Proposes a \$10 million increase in the 2005 Budget for this program to provide additional screenings.

Will work on developing outcome-oriented long-term measures and more ambitious long-term goals; and work toward increasing the number of cancer patients who start treatment within 60 days of diagnosis.

Status

Completed

Action taken, but not completed

Update on Follow-up Actions:

Program Funding Level (in millions of dollars)

<u>2004 Actual</u>	<u>2005 Estimate</u>	<u>2006 Estimate</u>
197	204	204

Program: *Chronic Disease -
 Diabetes*

Agency: *Department of Health and Human Services*

Bureau: *Centers for Disease Control and Prevention*

Rating: *Adequate*

Program Type: *Competitive Grant*

Last Assessed: *1 year ago*

<i>Key Performance Measures from Latest PART</i>	<i>Year</i>	<i>Target</i>	<i>Actual</i>
Annual Measure: Percentage of people with diabetes who receive the recommended eye and foot exams in States with comprehensive diabetes control programs funded by the program.	2004	72%/62%	
	2005	75%/70%	
	2006	75%/70%	
Annual Measure: Percentage of persons with diabetes who receive at least 2 blood sugar control measures per year in States with comprehensive diabetes control programs funded by the program.	2000		62.0%
	2001		63.3%
	2005	72.5%	
	2006	72.5%	

Recommended Follow-up Actions

Will work over the next year to develop the program's long-term health outcome measures, baselines and targets and measure progress on the annual performance goals.

Status

Action taken, but not completed

Update on Follow-up Actions:

Program Funding Level (in millions of dollars)

<u>2004 Actual</u>	<u>2005 Estimate</u>	<u>2006 Estimate</u>
60	63	63

Program: *Domestic HIV/AIDS
Prevention*

Agency: *Department of Health and Human Services*
Bureau: *Centers for Disease Control and Prevention*

Rating: *Results Not Demonstrated*

Program Type: *Competitive Grant*

Last Assessed: *1 year ago*

<i>Key Performance Measures from Latest PART</i>	<i>Year</i>	<i>Target</i>	<i>Actual</i>
Long-term Measure: Number of new HIV infections in the U.S.			
Annual Measure: Number of HIV infection cases diagnosed each year among people less than 25 years of age.	2000		2070
	2004	1,900	
	2005	1,800	
	2006	2,420	
Annual Measure: Proportion of all HIV-infected people who know they are infected.	1999		70%
	2004	80%	
	2005	80%	
	2006	80%	

Recommended Follow-up Actions

Status

Will maintain program funding to continue efforts to reduce the 40,000 new infections, specifically among minorities and women. Completed

Will modify the program targets for its long-term measures and collect data on the new annual performance indicators. Action taken, but not completed

Update on Follow-up Actions:

Program Funding Level (in millions of dollars)

<u>2004 Actual</u>	<u>2005 Estimate</u>	<u>2006 Estimate</u>
668	662	658

Program: *CDC State and Local Preparedness Grants*

Agency: *Department of Health and Human Services*
Bureau: *Centers for Disease Control and Prevention*

Rating: *Results Not Demonstrated*

Program Type: *Block/Formula Grant*

Last Assessed: *1 year ago*

<i>Key Performance Measures from Latest PART</i>	<i>Year</i>	<i>Target</i>	<i>Actual</i>
Annual Measure: Percentage of Laboratory Response Network labs that pass proficiency testing for Category A threat agents	2005	100%	
	2006	100%	
Long-term Measure: Percentage of states with level 1 chemical lab capacity, and agreements with/access to a level 3 chemical lab (specimens arriving within 8 hours)	2010	100%	
	2005	25%	
	2006	100%	
Annual Measure: Percentage of states with level 1 chemical lab capacity, and agreements with/access to a level 3 chemical lab (specimens arriving within 8 hours)	2005	25%	
	2006	100%	
	2007	100%	
	2008	100%	

Recommended Follow-up Actions

Will work with State and local representatives to ensure that performance information will be available to determine when acceptable preparedness has been demonstrated, and to target assistance for those areas that are not adequately prepared.

Has established outcome oriented goals and targets for preparedness.

Status

Action taken, but not completed

Action taken, but not completed

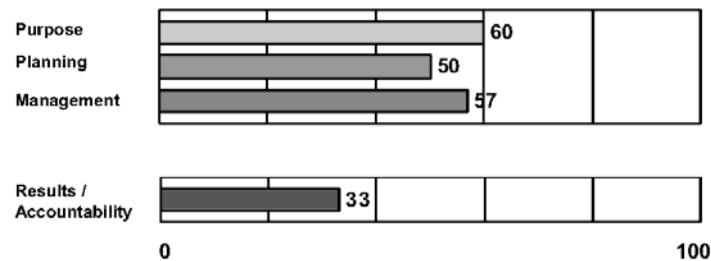
Update on Follow-up Actions:

Program Funding Level (in millions of dollars)

<u>2004 Actual</u>	<u>2005 Estimate</u>	<u>2006 Estimate</u>
918	927	797

Program: *CDC: Epidemic Services*

Agency: *Department of Health and Human Services*
Bureau: *Centers for Disease Control and Prevention*



Key Performance Measures from Latest PART **Year** **Target** **Actual**

Key Performance Measure	Year	Target	Actual
Long-term Measure: Reduced average elapsed time in days from the date of onset of the first case in an outbreak or public health incident to initiation of an investigation or other public health response to an event.	2001		15-23
	2003		13-16

Rating: *Results Not Demonstrated*

Program Type: *Direct Federal*

Program Summary:

The Epidemic Services activity at the Centers for Disease Control and Prevention (CDC) was established in 1981 to focus on disease surveillance and epidemic assistance, disease investigation and studies, and laboratory diagnostic references. The majority of Epidemic Services funding has been provided to the Epidemiology Program Office (EPO) at CDC.

The assessment found Epidemic Services at CDC has been managed well overall, but has not documented results on a wide variety of supported activities. The program has had no performance measures on the impact of disease surveillance and training efforts and no evaluations on many activities. Details from the assessment include:

- While individual components have a clear purpose, Epidemic Services overall has lacked a clear and coherent purpose.
- The program is not redundant of efforts outside of CDC, but there are programmatic and administrative redundancies within CDC.
- The program has struggled to place trainees at the State and local level, but it targets resources well overall and there is no evidence that the program subsidizes training and surveillance activities that would have occurred anyway.
- EPO has collaborated well with other parts of CDC, other Federal agencies, and State and international partners to target resources and accomplish its mission.
- EPO has supported numerous evaluations of individual program components that show the surveillance, training and dissemination efforts are largely effective.
- EPO developed a measure on the amount of time between when a disease outbreak or public health incident occurs and when the public health system responds.
- Activities supported by Epidemic Services outside of EPO have not had evaluations and there has been limited information and accountability for these activities.

In response to these factors:

1. CDC reorganized the Epidemic Services activity and EPO by consolidating functions with Health Information and Services activities, Global Health and Public Health Improvement and Leadership at CDC.
2. With the reorganization of EPO, CDC will no longer track EPO's measures, but the organizational units that are now responsible for EPO's functions will adopt these or similar measures in the future.
3. As is shown below, funding is maintained in 2005 and 2006. This funding has been reallocated within CDC as part of the reorganization. Beginning in 2005, Epidemic Services funding will no longer be tracked at the budget activity level.

Program Funding Level (in millions of dollars)

<u>2004 Actual</u>	<u>2005 Estimate</u>	<u>2006 Estimate</u>
92	92	92

EXHIBIT CC. FY 2004-2005 PART RECOMMENDATIONS

PART Recommendations for programs that were evaluated during the FY 2004 and 2005 budget cycles are included in this exhibit. These programs are: 317 Immunization Program, Breast and Cervical Cancer, Diabetes, Domestic HIV/AIDS Prevention, and State and Local Preparedness. In addition, this exhibit includes CDC-wide PART Recommendations that address issues at the agency-level.

317 IMMUNIZATION PROGRAM (FY 2004)

RECOMMENDATION		COMPLETION DATE	ON TRACK? (Y/N)
Undergo an independent evaluation on a regular basis, or as needed, to fill gaps in performance information to support program improvement and evaluate effectiveness.		6/1/06	Y
COMMENT ON STATUS			
Phase one of the evaluation was completed. Phase one evaluated the program mission, performance measures and objectives, and how the mission and objectives are being implemented by CDC and grantees. An economic evaluation of the relation between program inputs and outputs was conducted ahead of schedule, and a report of the findings is being finalized. The design and selection criteria for conducting case studies were completed. In preparation for the grantee survey, a draft of supporting documentation for the OMB formal clearance package to conduct a grantee survey was drafted.			
NEXT MILESTONE	NEXT MILESTONE DATE	LEAD ORGANIZATION	LEAD OFFICIAL
Contractor to carry out Section 317 grantee immunization survey.	8/31/05	CDC	Karen Long

RECOMMENDATION		COMPLETION DATE	ON TRACK? (Y/N)
Establish processes and procedures to measure and/or improve program efficiency - additional steps to improve vaccine distribution should be examined.		3/31/06	Y
COMMENT ON STATUS			
New business policies and procedures and processes were drafted and will be further refined in conjunction with the pilot testing. A request for information for commercial vaccine distribution services was announced in mid-December 2004.			
NEXT MILESTONE	NEXT MILESTONE DATE	LEAD ORGANIZATION	LEAD OFFICIAL
Develop a request for a proposal for commercial vaccine distribution services.	4/01/05	CDC	Karen Long

RECOMMENDATION		COMPLETION DATE	ON TRACK? (Y/N)
Improve mechanisms linking the program's budget for state immunization program operation activities to program performance.		4/30/06	Y
COMMENT ON STATUS			
Data collection was completed and analysis was conducted. Preliminary baseline information for the new efficiency performance measure was developed.			
NEXT MILESTONE	NEXT MILESTONE DATE	LEAD ORGANIZATION	LEAD OFFICIAL
Refine baseline information to reflect availability of more specific expenditure information.	3/31/05	CDC	Karen Long

BREAST AND CERVICAL CANCER (FY 2004)

RECOMMENDATION		COMPLETION DATE	ON TRACK? (Y/N)
Work on developing outcome-oriented long-term measures and more ambitious long-term goals.		2/28/05	Y
COMMENT ON STATUS			
CDC has retained contractor support to develop the Monitoring and Evaluation Plan corresponding to the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) Strategic Plan and to develop a Priority Plan for evaluation activities. The contract lapsed in October 2003 and was re-initiated in April 2004. GPRA targets are increased each fiscal year to reflect the Program's commitment to reaching long term goals established for 2008.			
NEXT MILESTONE	NEXT MILESTONE DATE	LEAD ORGANIZATION	LEAD OFFICIAL
(1) Further develop evaluation plan outcome measures. (2) Identify priorities for evaluation activities.	2/28/05	CDC	Karen Long

RECOMMENDATION		COMPLETION DATE	ON TRACK? (Y/N)
Collect performance data on an annual basis and make it available to the public.		3/31/05	Y
COMMENT ON STATUS			
CDC is engaged in the extensive clearance process for website infrastructure and web hosting. The completion of this project has been delayed due to the numerous steps in the clearance process			
NEXT MILESTONE	NEXT MILESTONE DATE	LEAD ORGANIZATION	LEAD OFFICIAL
CDC will develop Web infrastructure to share with the public on the CDC public Web site.	03/31/05	CDC	Karen Long
Data will be posted on the web for public dissemination.	3/31/05	CDC	Karen Long

RECOMMENDATION	COMPLETION DATE	ON TRACK? (Y OR N)	
Provide independent and quality comprehensive evaluations of the program that indicate that the program is effective and is achieving results.	2/28/05	Y	
COMMENT ON STATUS			
The final draft of the evaluation plan has been completed. Next steps are to identify and formulate effective evaluations. In addition, a protocol for Evaluation of Case management in the NBCCEDP has been developed through collaboration with the University of Michigan.			
NEXT MILESTONE	NEXT MILESTONE DATE	LEAD ORGANIZATION	LEAD OFFICIAL
Draft site visit reports from selected programs participating in a seven-state Evaluation of the Impact of the BCCPTA of 2000, conducted by George Washington University.	1/31/05	CDC	Karen Long
Dissemination of results from a 16-state evaluation of the State Implementation of the Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) of 2000, conducted by George Washington University.	1/31/05	CDC	Karen Long

RECOMMENDATION	COMPLETION DATE	ON TRACK? (Y/N)	
Develop procedures to measure and achieve efficiencies and cost effectiveness in program execution.	4/30/05	Y	
COMMENT ON STATUS			
Division of Cancer Prevention and Control (DCPC) has retained contractor support to interview program staff and collect economic "test" data from nine pilot programs, which will inform the process and develop recommendations for the collection of economic indicator data. Ongoing activities include compiling and reviewing data, and completing the action plan from the economic analysis.			
NEXT MILESTONE	NEXT MILESTONE DATE	LEAD ORGANIZATION	LEAD OFFICIAL
Develop cost effectiveness formula(s) through multiple regression analysis.	3/31/05	CDC	Karen Long

RECOMMENDATION		COMPLETION DATE	ON TRACK? (Y/N)
Measure and achieve efficiencies and cost effectiveness in program execution.		4/30/05	Y
COMMENT ON STATUS			
CDC has retained contractor support to interview program staff and collect economic "test" data from nine pilot programs, which will inform the process and develop recommendations for the collection of economic indicator data. Ongoing activities include compiling and reviewing data, and completing the action plan from the economic analysis.			
NEXT MILESTONE	NEXT MILESTONE DATE	LEAD ORGANIZATION	LEAD OFFICIAL
(1) Compile and review data from economic analysis. (2) Complete action plan for economic analysis.	4/30/05	CDC	Karen Long
Implement plan to apply cost effectiveness formula to program execution and grant award decisions.	4/30/05	CDC	Karen Long

RECOMMENDATION		COMPLETION DATE	ON TRACK? (Y/N)
Address strategic planning deficiencies.		3/31/05	Y
COMMENT ON STATUS			
CDC has retained contractor support to develop the Monitoring and Evaluation Plan corresponding to the NBCCEDP Strategic Plan and to develop a Priority Plan for evaluation activities. The contract lapsed in October 2003 and was re-initiated in April 2004.			
NEXT MILESTONE	NEXT MILESTONE DATE	LEAD ORGANIZATION	LEAD OFFICIAL
(1) Develop evaluation plan outcome measures (2) Identify annual priorities for evaluation activities.	02/28/05	CDC	Karen Long

DIABETES (FY 2004)

RECOMMENDATION		COMPLETION DATE	ON TRACK? (Y/N)
Work to develop the program's long-term health outcome goals in 2003.		3/31/05	Y
COMMENT ON STATUS			
<p>The final report of the study on projections of lower extremity amputations among people with diabetes was received in October 2004. Using national survey data and Medicare data on amputations, this study used various statistical models to develop projections of lower-extremity amputation (LEA). These analyses suggested that the number of persons with diabetes experiencing amputations is likely to grow rapidly between 2002 and 2050 among those less than 75 years of age. However, these projections of lower extremity amputations varied widely by the assumptions used to model the projections. The study concluded that additional years of data and additional state-level measures of diabetes care practices (e.g., foot exam, A1c testing) are needed for more reliable projections of amputations and to link programmatic diabetes care practices with health outcomes among people with diabetes. Therefore, CDC does not have sufficient data at this time to develop science-based goals for this health outcome. The program is exploring feasible alternatives to developing goals. Meanwhile, CDC continues to monitor trends in LEA and End-Stage Renal Disease in trend with either decreasing rates or rates that are leveling off.</p>			
NEXT MILESTONE	NEXT MILESTONE DATE	LEAD ORGANIZATION	LEAD OFFICIAL
CDC will use the report findings to inform program planning decisions and to determine whether this is the best approach to projecting diabetes complications.	1/30/05	CDC	Karen Long

RECOMMENDATION		COMPLETION DATE	ON TRACK? (Y/N)
Collect performance data on an annual basis and make it available to the public in a transparent and meaningful manner.		On-going	Y
COMMENT ON STATUS			
<p>FY 2003 data has been updated and is in the CDC clearance process. FY 2003 data are expected to be cleared and on the CDC website in February 2005.</p>			
NEXT MILESTONE	NEXT MILESTONE DATE	LEAD ORGANIZATION	LEAD OFFICIAL
CDC will continue to update data and post to the website as quickly as data analysis and clearance process will permit.	On-going	CDC	Karen Long

RECOMMENDATION		COMPLETION DATE	ON TRACK? (Y/N)
Demonstrate improved efficiencies and cost effectiveness in achieving program goals.		10/01/05	Y
COMMENT ON STATUS			
The management analysis was completed January 2005 by an outside contractor. This analysis was initiated to determine how resources (i.e. human capital, time and funds) are being used to achieve National Program Objectives (NPO). The analysis successfully captured the internal and external influence, interaction and impact of resources but indicated that more information would be needed to clearly link the resources to the NPO. CDC will continue working with the contractor to identify strategies that will enable CDC to demonstrate improved efficiencies, and cost effectiveness. In addition, the results will help CDC determine the Balanced Scorecard (BSC) components and which of these components to address first.			
NEXT MILESTONE	NEXT MILESTONE DATE	LEAD ORGANIZATION	LEAD OFFICIAL
Diabetes Management staff are conducting a management analysis and integrating the strategic planning and Balanced Scorecard (BSC) goals and objectives and developing a BSC map to summarize goals and objectives. The Division of Diabetes Translation will align the program goals with the center and agency Futures Initiative goals.	On-going	CDC	Karen Long
Division is continuing efforts to establish a score card that is congruent with the Center and the agency.	On-going	CDC	Karen Long

RECOMMENDATION		COMPLETION DATE	ON TRACK? (Y/N)
Align budget with program goals so that the impact of funding, policy, and legislative changes on performance is readily known.		10/01/05	Y
COMMENT ON STATUS			
The results of the recently completed management analysis provided important information about how resources are being used, but indicated that more information will be needed to clearly link the budget to program goals. The program will use the results of the analysis to define key components for a Balanced Score Card (BSC) and a plan of action.			
NEXT MILESTONE	NEXT MILESTONE DATE	LEAD ORGANIZATION	LEAD OFFICIAL
Division is continuing efforts to establish a score card that is congruent with the center and the agency.	On-going	CDC	Karen Long
Division is assessing the capability of the MIS to capture more data to help assess impact.	On-going	CDC	Karen Long

The following recommendation for the Diabetes program has been completed:

- Conduct independent and quality comprehensive evaluations of the program that indicate that the program is effective and is achieving results.

DOMESTIC HIV/AIDS PREVENTION (FY 2004)

RECOMMENDATION		COMPLETION DATE	ON TRACK? (Y/N)
Develop methods to estimate level of resources required to reach program goals.		On-going	Y
COMMENT ON STATUS			
CDC is working on a cost model for HIV transmission that focus on the role of prevalent HIV cases and that will allow for the evaluation of the effects of various prevention efforts on future HIV incidence.			
NEXT MILESTONE	NEXT MILESTONE DATE	LEAD ORGANIZATION	LEAD OFFICIAL
Complete development of a cost model for HIV incidence.	9/30/05	CDC	Karen Long

RECOMMENDATION		COMPLETION DATE	ON TRACK? (Y/N)
Hold federal managers and grantees accountable for program performance.		On-going	Y
COMMENT ON STATUS			
CDC is working to revise federal managers' (both Commissioned Corps and Civil Service) workplans to link employee performance with program performance.			
NEXT MILESTONE	NEXT MILESTONE DATE	LEAD ORGANIZATION	LEAD OFFICIAL
Work with the Commissioned Corps Office to determine if the goal section of the Commissioned Officer Effectiveness Report can be utilized to link the Officer's Performance Review to program performance. If this is possible, revise COERs as necessary. If it is not possible, work with Commissioned Corps Office to develop new instrument.	2/28/05	CDC	Karen Long
Work with the Atlanta Human Resource Office to further modify performance plans for Civil Service employees in order to link employee performance plans with program performance.	2/28/05	CDC	Karen Long

RECOMMENDATION		COMPLETION DATE	ON TRACK? (Y/N)
Develop incentives and procedures to measure and achieve efficiencies and cost-effectiveness in program execution.		On-going	Y
COMMENT ON STATUS			
The Division of AIDS, STD and TB Laboratory Research within CDC has been reorganized to align each laboratory component with its respective division. CDC is analyzing the report on the efficiencies achieved by this reorganization.			
NEXT MILESTONE	NEXT MILESTONE DATE	LEAD ORGANIZATION	LEAD OFFICIAL
Report on savings from bulk purchase of test kits and train-the-trainer sessions.	01/31/05	CDC	Karen Long

RECOMMENDATION		COMPLETION DATE	ON TRACK? (Y/N)
Improve oversight of grantee activities.		On-going	Y
COMMENT ON STATUS			
Phase I of the Program Evaluation Monitoring System (PEMS) has been implemented.			
NEXT MILESTONE	NEXT MILESTONE DATE	LEAD ORGANIZATION	LEAD OFFICIAL
Receipt and analysis of progress reports from state health departments, CBOs, and CBA providers	9/30/05	CDC	Karen Long

RECOMMENDATION		COMPLETION DATE	ON TRACK? (Y/N)
Collect data on program performance and make it available publicly.		On-going	Y
COMMENT ON STATUS			
The progress report on the <i>HIV Prevention Strategic Plan</i> is currently undergoing CDC clearance prior to submission to HHS for its clearance. In addition, CDC developed a template to review grantee performance. That template is undergoing review and clearance prior to implementation during Summer 2005.			
NEXT MILESTONE	NEXT MILESTONE DATE	LEAD ORGANIZATION	LEAD OFFICIAL
None	None	CDC	Karen Long

STATE AND LOCAL PREPAREDNESS (FY 2005)

RECOMMENDATION		COMPLETION DATE	ON TRACK? (Y/N)
Develop and conduct independent program evaluations.		12/31/05	Y
COMMENT ON STATUS			
Key performance indicators and outcome objectives for state and local preparedness have been developed and are being incorporated into new cooperative agreement guidance for FY 2005 – 2006. Independent evaluations will be based upon these objectives and indicators.			
NEXT MILESTONE	NEXT MILESTONE DATE	LEAD ORGANIZATION	LEAD OFFICIAL
Coordinate independent on-site evaluations.	12/31/05	CDC	Karen Long

The following recommendation for the State and Local Preparedness program has been completed:

- Link performance and measures.

CDC-WIDE

RECOMMENDATION		COMPLETION DATE	ON TRACK? (Y/N)
Explicitly tie budget requests to the accomplishment of annual and long-term goals, and present resource needs in a complete and transparent manner.		On-going	Y
COMMENT ON STATUS			
<p>CDC developed and piloted a marginal cost methodology in conjunction with HHS. During the HHS Budget and Performance Training Day on October 22, 2004, CDC explained the criteria for program selection and current marginal cost activities. CDC is now coordinating with HHS to complete the report for the TB pilot. The marginal cost methodology and pilot results will be distributed once the TB Prevention Marginal Cost Report is complete.</p> <p>This FY 2006 Congressional Justification is CDC's first submission to Congress combining budget and performance information into one document. The integrated "Performance Budget" more closely links GPRA goals with budget requests and full cost estimates.</p> <p>Members of the Goals Management Team presented written and oral reports to CDC's Executive Leadership Board (ELB) on December 7, 2004. These reports provided ELB members with findings and recommendations from the Goals Management pilot teams (Adolescents, Adults, and Preparedness Teams). Components of these reports included:</p> <ul style="list-style-type: none"> • Team Reports (from each of the three pilot teams) • Application of Complex Systems – Infant Mortality • Addressing Health Equity in Goals Management • 2004 Budget Allocation by Life Stage • A Comprehensive Plan for Change Management <p>The findings and recommendations from these reports will assist CDC as it moves forward with its Goals Management process.</p>			
NEXT MILESTONE	NEXT MILESTONE DATE	LEAD ORGANIZATION	LEAD OFFICIAL
Disseminate marginal cost methodology developed from the two pilots to all HHS OPDIV/STAFFDIV performance and budget officers. Hold a workshop for FDA and CDC to present the marginal cost methodology to the OPDIVs/STAFFDIVs.	03/31/05	CDC	Karen Long

RECOMMENDATION	COMPLETION DATE	ON TRACK? (Y/N)	
Use strong financial management practices.	4/30/05	Y	
COMMENT ON STATUS			
<p>CDC has made significant progress with its Unified Financial Management System (UFMS) implementation. Specific activities and accomplishments include:</p> <ul style="list-style-type: none"> • Phase 1 and 2 "Go Live" – With the successful completion of phases 1 and 2, the General Ledger, Accounting For Pay System (AFPS), and Grants Processing modules are in place. General ledger includes CDC's overall accounting "books." Implementation of AFPS aligns CDC's method of payroll accounting with a department-wide standardized process. With grants processing, CDC will process two critical business functions – representing over 55 percent of its dollars and transactions – in UFMS. • Travel Order and Voucher Submissions – Under new travel processes, the financial system will not accept travel vouchers that exceed the travel order amount by more than 10% or \$100, whichever is less. • Training Vendor Identification and Payment Processing – Training request submissions for which payment is to be made by training order require that the vendor be identified and selected in the Training System vendor file. Training requests for \$2,500 or less should be paid by credit card or convenience check whenever possible. • Use of Miscellaneous Obligations Documents (6012s) – CDC now accepts 6012s only for specific items and events. Further, the budget branch must approve the 6012 before the accounting branch will obligate any funds. • Automation of Local Travel Processing – Local travelers now complete, edit, and submit claims for mileage, parking, MARTA, and local transportation expenses through an automated system. The system provides the ability to review, assign, audit, or reject travel vouchers. • Retirement of Small Purchases and Procurement System (SPPS) – SPPS will be retired for FY 2005. ICE and Visa IMPAC will be used in its place. 			
NEXT MILESTONE	NEXT MILESTONE DATE	LEAD ORGANIZATION	LEAD OFFICIAL
Implement the full suite of Oracle/UFMS modules (Accounts Payable, Accounts Receivable, Purchasing, Budget Execution, Project Accounting).	4/30/05	CDC	Karen Long

EXHIBIT DD. SUMMARY OF MEASURES

The table below provides a summary of CDC's performance measures. Note that ATSDR performance measures are not included in this exhibit.

SUMMARY OF MEASURES								
FY	Measures				Results			
	Total in Plan	Outcome	Output	Efficiency	Reported	Met	Unmet	Unreported
2002	178	43	135	0	175	135	40	3
2003*	132	42	90	0	122	105	17	10
2004	119	50	63	6	70	58	12	49
2005	132	55	60	17	N/A	N/A	N/A	N/A
2006	120	51	55	14	N/A	N/A	N/A	N/A

* FY 2003 data have been revised based on updated information.

RESEARCH COORDINATION COUNCIL (RCC)

RESEARCH PRIORITY:	FY 2006 BUDGET REQUEST (\$ IN 000)
I. Working Towards Independence	\$0
II. Rallying the Armies of Compassion	\$830
III. No Child Left Behind	\$30,078
IV. Promoting Active Aging and Improving Long-Term Care	\$4,987
V. Protecting and Empowering Specific Populations	\$7,657
VI. Helping the Uninsured and Increasing Access to Health Insurance	\$1,250
VII. Realizing the Possibilities of 21 st Century Health Care	\$31,828
VIII. Ensuring Our Homeland is Prepared to Respond to Health Emergencies	\$46,594
IX. Understanding Health Differences and Disparities—Closing the Gaps	\$41,794
X. Preventing Disease, Illness, and Injury	\$494,252
XI. Agency-specific Priorities	\$0
Total RD&E	\$659,270

CDC and ATSDR conduct research, development, demonstration, and evaluation (RD&E) activities in support of their mission to promote health and quality of life by preventing and controlling disease, injury, and disability. These activities clearly align with the Secretary's and the President's priority areas. Several features distinguish CDC/ATSDR's RD&E activities from those of other agencies, including a strong emphasis on prevention rather than treatment, a focus on population health (in addition to the health of individuals within the population), and the dominance of collaborative RD&E activities with a host of federal, state, local, and international partners (as opposed to pure extramural or intramural RD&E).

In addition, CDC/ATSDR research is primarily positioned on the applied and explanatory end of the research spectrum rather than at the basic science end of the spectrum. CDC/ATSDR conducts RD&E primarily to develop and improve disease prevention programs which can be applied at the population or community level. This focus complements those of other agencies and organizations. CDC emphasizes applied prevention research designed to translate proven strategies into public health practice at the national, state, and local levels. As part of this effort, CDC also supports the evaluation of the prevention effectiveness of state programs through ongoing research, and synthesis and dissemination of findings.

CDC and ATSDR coordinate their RD&E activities with other agencies and organizations to avoid duplication and to build cooperation and synergy. For example, the Racial and Ethnic Approaches to Community Health (REACH) program is a collaboration between CDC, NIH, the Administration on Aging, and the California Endowment. The National Diabetes Education Program is a joint program of CDC and NIH's National Institute of Diabetes and Digestive and Kidney Diseases. Additionally, CDC's food safety research is coordinated with FDA and the Department of Agriculture. These are just a few examples of the numerous collaborative RD&E efforts underway.

The Research Coordination Council (RCC) facilitates the prioritization of research needs and the elimination of duplication among HHS operating divisions. The RCC and the associated working groups have allowed an informative dialog between the agencies. For example, while NIH and CDC descriptions of bioterrorism research initially seemed to be duplicative, it became clear that the roles and responsibilities are complementary. As a result of the RCC process, there is the potential for increased joint participation with NIH in research, planning, and demonstration projects. The RCC interaction has highlighted and confirmed the importance of CDC/ATSDR's collaboration with other agencies. The opportunity to view RD&E activities across agencies has allowed important gaps to be recognized. Working together has also enforced the teamwork of "one HHS". CDC/ATSDR looks forward to further meetings and discussions of the RCC to improve research HHS-wide.

MECHANISM TABLE - BUDGET ACTIVITY

Budget Activity	FY 2004 Actual	FY 2005 Enacted *	FY 2006 Estimate *	FY 2006 +/- FY 2005
Infectious Diseases (Proposed Law)	\$1,654,394	\$1,665,329	\$1,609,758	(\$55,571)
Intramural Research and Program Assistance	\$431,685	\$431,720	\$426,149	(\$5,571)
Extramural Programs	\$1,192,078	\$1,199,617	\$1,149,617	(\$50,000)
PHS Evaluation Assessments	\$30,631	\$33,992	\$33,992	\$0
Health Promotion	\$932,067	\$1,024,033	\$964,421	(\$59,612)
Intramural Research and Program Assistance	\$182,736	\$198,932	\$198,144	(\$788)
Extramural Programs	\$731,777	\$804,003	\$745,179	(\$58,824)
PHS Evaluation Assessments	\$17,554	\$21,098	\$21,098	\$0
Health Information and Service	\$210,516	\$228,673	\$223,799	(\$4,874)
Intramural Research and Program Assistance	\$170,232	\$186,674	\$186,720	\$46
Extramural Programs	\$39,740	\$40,256	\$35,336	(\$4,920)
PHS Evaluation Assessments	\$544	\$1,743	\$1,743	\$0
Environmental Health and Injury	\$282,926	\$285,721	\$284,819	(\$902)
Intramural Research and Program Assistance	\$91,721	\$92,276	\$91,374	(\$902)
Extramural Programs	\$185,632	\$187,558	\$187,558	\$0
PHS Evaluation Assessments	\$5,573	\$5,887	\$5,887	\$0
Occupational Safety and Health	\$276,988	\$286,041	\$285,930	(\$111)
Intramural Research and Program Assistance	\$160,653	\$165,904	\$165,793	(\$111)
Extramural Programs	\$116,335	\$120,137	\$120,137	\$0
PHS Evaluation Assessments	\$0	\$0	\$0	\$0
Global Health	\$285,983	\$293,863	\$306,079	\$12,216
Intramural Research and Program Assistance	\$2,860	\$2,939	\$3,077	\$138
Extramural Programs	\$275,138	\$284,870	\$296,948	\$12,078
PHS Evaluation Assessments	\$7,985	\$6,054	\$6,054	\$0
Public Health Research	\$29,107	\$31,000	\$31,000	\$0
Intramural Research and Program Assistance	\$1,224	\$1,860	\$1,860	\$0
Extramural Programs	\$27,361	\$29,140	\$29,140	\$0
PHS Evaluation Assessments	\$522	\$0	\$0	\$0
Public Health Improvement & Leadership	\$232,824	\$266,843	\$206,541	(\$60,302)
Intramural Research and Program Assistance	\$137,171	\$146,466	\$146,614	\$148
Extramural Programs	\$94,349	\$119,967	\$59,517	(\$60,450)
PHS Evaluation Assessments	\$1,304	\$410	\$410	\$0
Prev. Health & Health Services Block Grant	\$131,814	\$130,759	\$0	(\$130,759)
Intramural Research and Program Assistance	\$1,318	\$1,308	\$0	(\$1,308)
Extramural Programs	\$130,496	\$129,451	\$0	(\$129,451)
PHS Evaluation Assessments	\$0	\$0	\$0	\$0

SUPPORTING INFORMATION
MECHANISM TABLE - BUDGET ACTIVITY

Budget Activity	FY 2004 Actual	FY 2005 Enacted *	FY 2006 Estimate *	FY 2006 +/- FY 2005
Building and Facilities	\$260,454	\$269,708	\$30,000	(\$239,708)
Intramural Research and Program Assistance	\$260,454	\$269,708	\$30,000	(\$239,708)
Extramural Programs	\$0	\$0	\$0	\$0
PHS Evaluation Assessments	\$0	\$0	\$0	\$0
Business Services Support	\$282,226	\$278,840	\$263,716	(\$15,124)
Intramural Research and Program Assistance	\$282,226	\$278,840	\$263,716	(\$15,124)
Extramural Programs	\$0	\$0	\$0	\$0
PHS Evaluation Assessments	\$0	\$0	\$0	\$0
CDC Total (Proposed Law)	\$4,579,299	\$4,760,810	\$4,206,063	(\$554,747)
Intramural Research and Program Assistance	\$1,722,280	\$1,776,627	\$1,513,447	(\$263,180)
Extramural Programs	\$2,792,906	\$2,914,999	\$2,623,432	(\$291,567)
PHS Evaluation Assessments	\$64,113	\$69,184	\$69,184	\$0
Agency for Toxic Substances and Disease Registry	\$73,034	\$76,041	\$76,024	(\$17)
Intramural Research and Program Assistance	\$59,888	\$62,354	\$62,337	(\$17)
Extramural Programs	\$13,146	\$13,687	\$13,687	\$0
PHS Evaluation Assessments	\$0	\$0	\$0	\$0
Terrorism	\$1,507,211	\$1,560,445	\$1,616,723	\$56,278
Intramural Research and Program Assistance	\$331,586	\$343,298	\$342,576	(\$722)
Extramural Programs	\$1,175,625	\$1,217,147	\$1,274,147	\$57,000
PHS Evaluation Assessments	\$0	\$0	\$0	\$0
Vaccines for Children (Proposed Law)	\$1,052,030	\$1,634,851	\$1,642,333	\$7,482
Intramural Research and Program Assistance	\$10,520	\$16,349	\$16,349	\$0
Extramural Programs	\$1,041,510	\$1,618,502	\$1,625,984	\$7,482
PHS Evaluation Assessments	\$0	\$0	\$0	\$0
PHS Evaluation Transfers	\$212,134	\$265,100	\$265,100	\$0
Intramural Research and Program Assistance	\$116,674	\$145,805	\$145,805	\$0
Extramural Programs	\$95,460	\$119,295	\$119,295	\$0
PHS Evaluation Assessments	\$0	\$0	\$0	\$0
CDC/ATSDR Program Level Total (Proposed Law) ¹	\$7,211,574	\$8,032,147	\$7,541,143	(\$491,004)
Intramural Research and Program Assistance	\$2,124,274	\$2,198,628	\$1,934,709	(\$263,919)
Extramural Programs	\$5,023,187	\$5,764,335	\$5,537,250	(\$227,085)
PHS Evaluation Assessments	\$64,113	\$69,184	\$69,184	\$0

¹ Funding levels do not include total amount for user fees (\$2226).

* FY 2005 and FY 2006 allocations for extramural and intramural spending are estimates.

CROSSWALK – FUNDING BY PROGRAM AND ORGANIZATION (FY 2004)

CDC FINANCING BY PROGRAM AND ORGANIZATION -- FY 2004 (dollars in thousands)												
	ATSDR	CCID	CCHP	CCHIS	CCEHIP	NIOSH	OGH	OTPER	PHIL ¹	OD	BSS	Total
Infectious Diseases		1,654,394										1,654,394
Health Promotion			932,067									932,067
Health Information and Services				210,516								210,516
Environmental Health and Injury					282,925							282,925
Occupational Safety and Health						276,988						276,988
Global Health							285,983					285,983
Public Health Research										29,107		29,107
Public Health Improvement & Leadership									232,824			232,824
Prev. Hlth./Hlth. Services Block Grant			131,814									131,814
Building & Facilities										260,454		260,454
Business Services Support											282,226	282,226
Total, CDC	0	1,654,394	1,063,881	210,516	282,925	276,988	285,983	0	232,824	289,561	282,226	4,579,299
Agency for Toxic Substances & Disease Registry	73,034											73,034
Terrorism								1,507,211				1,507,211
Vaccines For Children		1,052,030										1,052,030
Total, CDC/ATSDR²	73,034	2,706,424	1,063,881	210,516	282,925	276,988	285,983	1,507,211	232,824	289,561	282,226	7,211,574

¹ Funding for the Leadership & Management portion of Public Health Improvement and Leadership is allocated to each Coordinating Center and Coordinating Office. The FY 2005 allocation has not been finalized; therefore, FY 2004 and FY 2006 could not be made comparable.

²Total for CDC/ATSDR does not include User Fees (\$2,226).

CROSSWALK – FUNDING BY PROGRAM AND ORGANIZATION (FY 2005)

CDC FINANCING BY PROGRAM AND ORGANIZATION - FY 2005 (dollars in thousands)												
	ATSDR	CCID	CCHP	CCHIS	CCEHIP	NIOSH	OGH	OTPER	PHIL ¹	OD	OCOO	Total
Infectious Diseases		1,665,330										1,665,330
Health Promotion			1,024,033									1,024,033
Health Information and Services				228,673								228,673
Environmental Health and Injury					285,721							285,721
Occupational Safety and Health						286,041						286,041
Global Health							293,863					293,863
Public Health Research										31,000		31,000
Public Health Improvement & Leadership									266,843			266,843
Prev. Hlth./Hlth. Services Block Grant			130,759									130,759
Building & Facilities										269,708		269,708
Business Services Support											278,840	278,840
Total, CDC	0	1,665,330	1,154,792	228,673	285,721	286,041	293,863	0	266,843	300,708	278,840	4,760,811
Agency for Toxic Substances & Disease Registry	76,041											76,041
Terrorism								1,560,445				1,560,445
Vaccines For Children		1,634,850										1,634,850
Total, CDC/ATSDR²	76,041	3,300,180	1,154,792	228,673	285,721	286,041	293,863	1,560,445	266,843	300,708	278,840	8,032,147

¹Funding for the Leadership & Management portion of Public Health Improvement and Leadership is allocated to each Coordinating Center and Coordinating Office. The FY 2005 allocation has not been finalized; therefore, FY 2004 and FY 2006 could not be made comparable.

²Total for CDC/ATSDR does not include User Fees (\$2,226).

CROSSWALK – FUNDING BY PROGRAM AND ORGANIZATION (FY 2006)

CDC FINANCING BY PROGRAM AND ORGANIZATION - FY 2006 (dollars in thousands)												
	ATSDR	CCID	CCHP	CCHIS	CCEHIP	NIOSH	OGH	OTPER	PHIL¹	OD	BSS	Total
Infectious Diseases ²		1,609,758										1,609,758
Health Promotion			964,421									964,421
Health Information and Services				223,799								223,799
Environmental Health and Injury					284,820							284,820
Occupational Safety and Health						285,930						285,930
Global Health							306,079					306,079
Public Health Research										31,000		31,000
Public Health Improvement & Leadership									206,541			206,541
Prev. Hlth./Hlth. Services Block Grant			0									0
Building & Facilities										30,000		30,000
Business Services Support											263,715	263,715
Total, CDC	0	1,609,758	964,421	223,799	284,820	285,930	306,079	0	206,541	61,000	263,715	4,206,063
Agency for Toxic Substances & Disease Registry	76,024											76,024
Terrorism								1,616,723				1,616,723
Vaccines For Children		1,642,333										1,642,333
Total, CDC/ATSDR³	76,024	3,252,091	964,421	223,799	284,820	285,930	306,079	1,616,723	206,541	61,000	263,715	7,541,143

¹ Funding for the Leadership & Management portion of Public Health Improvement and Leadership is allocated to each Coordinating Center and Coordinating Office. The FY 2005 allocation has not been finalized; therefore, FY 2004 and FY 2006 could not be made comparable.

²The FY 2006 budget request reflects the Proposed Law transfer of \$100 million from the discretionary Section 317 Program to the mandatory Vaccines For Children program.

³Total for CDC/ATSDR does not include User Fees (\$2,226).

PRESIDENT'S MANAGEMENT AGENDA

PRESIDENT'S MANAGEMENT AGENDA

OVERVIEW

Included in this section are key program management activities CDC has engaged in to address key aspects of the President's Management Agenda (PMA). The activities below will briefly describe CDC's progress in these areas and outline some important initiatives designed to help further improve the agency's program management.

CDC has been actively pursuing goals and improvements related to the PMA for several years. For example, CDC decreased its proportion of administrative positions by six percent from 1997 to 2001. CDC has historically focused on keeping the agency market-based and efficient by having approximately 6,000 service contractor staff engaged to conduct commercially-oriented responsibilities. In addition, CDC established its Fiscal Management Excellence Initiative in 2000, which has further enhanced its improvements in fiscal performance. CDC is also organized to effectively address and lead PMA issues. For example, CDC has established a Management Council to help concentrate management attention on the PMA.

PROGRESS ON PRESIDENT'S MANAGEMENT AGENDA

CDC made major achievements in addressing the President's Management Agenda (PMA) objectives. CDC has consolidated or restructured nearly 40 major human capital or business services improvements and more than doubled its supervisory ratio, thereby making the agency more efficient and effective. Similarly, CDC has met the FY 2002, 2003, and 2004 Competitive Sourcing goals set by OMB and HHS. Another major, successful effort is implementing HHS' Unified Financial Management System (UFMS) which will integrate the Department's financial management structure and provide HHS leaders with a more timely and coordinated view of critical financial management information. Furthermore, CDC has made extraordinary progress in Expanded Electronic Government initiatives, such as consolidating IT infrastructure services, having a leadership role in the establishment of a multi-department architecture for the President's Biosurveillance Initiative, and being actively engaged in HHS' modernization efforts. CDC's efforts to integrate budget and performance have taken on increased significance as the agency works to implement a new strategy and organization under the Futures Initiative. Recently, the agency announced modernizations to enhance health impact, support the capacity to respond to public health emergencies, and to directly engage CDC's customers, the American public.

STRATEGIC MANAGEMENT OF HUMAN CAPITAL INITIATIVE

CDC's significant growth in the size of its workforce over the past years is attributable to an ever-expanding public health mission. From FY 1996 to present, the number of employees has grown from 6,406 to 9,345 – an increase of 46 percent. This trend clearly reflects the agency's expanded disease prevention and control responsibilities. CDC's workforce is comprised of individuals working in over 170 job series with an emphasis on scientific and medical occupations. Approximately two-thirds of CDC employees work in the Atlanta headquarters area; however, the agency has a major presence (defined here as more than 50 employees) in such diverse geographical areas as Cincinnati, OH; Morgantown, WV; Hyattsville, MD; Pittsburgh, PA; Washington, D.C.; Spokane, WA; Durham, NC; and Fort Collins, CO. CDC's overseas presence will be up to 200 employees within the next year.

WORKFORCE RESTRUCTURING

CDC continues to promote and enhance its Strategic Management of Human Capital initiatives in support of the PMA. These initiatives include reducing layering, eliminating administrative positions through consolidation, further improving our supervisory ratio, and supporting the transition of our workforce toward providing more frontline public health functions.

CDC had already consolidated most of its program support offices to eliminate duplication prior to the PMA. Centralized offices included equal employment opportunity, procurement, human resources, facilities operations, security and emergency preparedness, and others. This consolidation resulted in substantial savings and efficiencies. CDC has undertaken a wide range of additional administrative consolidations and business improvements, including:

Administrative Consolidations

- CDC more than doubled its supervisory ratio from 1:5.5 in 2002 to over 1:12 in 2004. This documents the overall success in flattening organizations, reducing management layers, and consolidating and/or restructuring administrative functions.
- CDC consolidated 13 information technology (IT) infrastructure functions, services, staff and fiscal resources into the new Information Technology Services Office (ITSO). This consolidation reduced operating costs by 21 percent (\$23 million) and staff by 18 percent.

- A complex and innovative approach to administrative/management consolidation was used to functionally merge the Office of the Director (OD) in both ATSDR and NCEH into one unit. FTE savings of 18 percent (35 FTEs) have already been realized.
- CDC is effectively completing its Business Services Consolidation Plan. This is an overarching strategy, approved by HHS in July 2003, to reduce administrative positions, centralize reporting and supervisory relationships, and establish agency-wide shared services.
- CDC consolidated the agency's medical and professional inquiry hotlines. CDC awarded a performance-based contract for consolidated public and professional health information services reducing over 40 hotlines to one. This will expand services (24x365, multilingual, hearing impaired) and save about \$35 million over seven years.
- CDC completed the evaluation and detailed planning for budget execution services consolidation in FY 2004. In October 2004, CDC consolidated budget execution services across the agency. This action successfully resulted in a 20 percent reduction of staff working in budget execution services, or a decrease of 61 FTEs. Comprehensive Service Level Agreements are in place.
- CDC completed the evaluation and detailed planning for consolidation of graphics services. Implementation of consolidated graphics services across the agency is expected to be complete in FY 2005. This action will result in fiscal and staff savings that can be redirected to mission direct activities, including savings expected from more efficient use of equipment.
- CDC completed the evaluation and detailed planning for the consolidation of professional training services. Implementation of consolidated professional training services across the agency is expected to be complete in FY 2005 - 2006.
- CDC completed the evaluation and detailed planning for consolidation of travel services in 2005 with associated fiscal and staff savings for redirection to mission direct activities. CDC is currently awaiting rollout of HHS' e-travel services to assure proper coordination with these two processes.
- CDC, with HHS' guidance, completed the restructuring of its human resources office to the HHS Atlanta Human Resources Center (AHRC). This human resources office restructuring eliminated 76 FTEs, reflecting a 30 percent staff reduction. Despite this reduction, the time from AHRC's receipt of a hiring request to the day the job offer is made has been reduced by 47 percent between 2003 and 2004.
- CDC consolidated administrative functions in approximately 30 CDC/OD offices, reducing staffing from a baseline of 83 FTEs to 63, or a savings of 24 percent. This action resulted in staff savings that can be redirected to mission direct activities.
- As a result of these human capital and other CDC business services improvements, the agency reduced its number of mission support (administrative) staff by nearly 600 by January 2005. This reduction of over 15 percent of mission support staff will allow the redirection of administrative staff positions to front line public health efforts.

Other Business Process Improvements

- The Futures Initiative involves a range of evolving restructurings and efficiencies. For example, the CDC Director's span of direct reports was reduced from 23 to 15. In addition, in September 2004, CDC abolished two major program offices as part of the Futures Initiative. Staff from the two associated Offices of the Director have been redeployed within the new Coordinating Center for Health Information and Service, the new Office of Workforce and Career Development, or in other CDC programs
- Implementation of a state-of-the-art financial system is underway. UFMS is part of a multi-year effort initiated by Former Secretary Thompson. CDC has "gone live" with UFMS's General Ledger and Accounting for Pay System in October 2004. The grants interface (Grants Solution) was also implemented in the first quarter of FY 2005. This will cover more than 50 percent of the dollar and transaction volume of the agency. Full UFMS implementation is planned for April 2005.
- CDC is improving procurement and grants operations. Operational improvement opportunities have been identified that will result in increased employee productivity through workforce alignment, process redesign, and operational performance management. This effort has already resulted in new contract cycle time being reduced by 26 percent between 2003 and 2004.
- CDC is evaluating vaccine purchase processes to streamline CDC's purchase of over half of the nation's childhood vaccines through its Vaccine Management Improvement Project.

- The Office of Personnel Management has approved CDC/ATSDR's plan to offer Voluntary Separation Incentive Payments (VSIPs), or buyouts, to staff who work in mission support functions in 2005. Approximately 300 mission support staff have applied and been approved for these buyouts. CDC's plan is to use the VSIPs to help implement major reorganizations and business services consolidations which will result in significant business efficiencies and redeployment of positions to front line public health efforts.
- CDC has effectively used Voluntary Early Retirement Authority (VERA) to reduce mission support staff and restructure efficiencies accordingly. In FY 2003, 61 staff accepted VERA. In FY 2004, 36 staff accepted VERA.

Delaying Actions

CDC has completed layering the agency to no more than four management layers. In total, CDC abolished over 200 "Sections" in response to this initiative. This "Section" layering has contributed to a 33 percent decrease in the official number of organizational units at CDC since 2001. This agency-wide approach resulted in compressing the distance between citizens and decision-makers.

FY 2006 ACTIVITIES

- CDC will continue to flatten the agency by further improving its supervisory ratio.
- CDC/ATSDR will continue efforts to redirect more mission support staff to mission direct positions.
- CDC will strategically retrain and redeploy employees impacted by initiatives such as competitive sourcing, consolidations, and reduction of mission support positions.
- CDC will continue to use Voluntary Early Retirement Authority, Voluntary Separation Incentive Pay, and other innovative approaches to facilitate strategic management of human capital initiatives.

PERFORMANCE GOALS AND MEASURES

GOAL 1: DECREASE THE TIME NEEDED TO CLASSIFY POSITIONS AND REFER CANDIDATES FOR VACANCIES.			
Performance Measure	Targets	Actual Performance	Ref
1. Decrease the time needed to refer candidates to fill positions.	FY 2004: < 55 days to refer	FY 2004: 5.7 days to classify; 56.4 days to refer (Unmet) FY 2003: 13.7 days to classify; 64.7 days to refer FY 2002: 13.4 days to classify; 61.1 days to refer	-1

Goal 1, Performance Measure 1:

The number of days to refer is based on the requisition to certificate issued dates. The Atlanta Human Resources Center service level agreement does not include a single goal for days to refer, but rather is a series of goals for actions in the examining and referral process. This measure will be retired after data are reported for FY 2004.

GOAL 2: ENHANCE WORKFORCE PLANNING EFFORTS AT CDC.			
Performance Measure	Targets	Actual Performance	Ref
1. Improve supervisory ratio.	FY 2004: Increase supervisory ratio to 1:9 FY 2003: Increase supervisory ratio to 1:8	FY 2004: 1:11.5 (Exceeded) FY 2003: 1:10 (Exceeded) FY 2002: 1:6.8	-1
2. Increase the span of control and organizational size.	FY 2003: Increase the minimum number of FTEs required to 11 FTEs per branch and 6 FTEs per section	FY 2003: CDC abolished all Sections and has an average of 25 FTEs per Branch (Met) FY 2002: CDC guidance requires a minimum of 10 FTEs per branch and a minimum of 5 FTEs per section	-1

Goal 2, Performance Measures 1 and 2:

CDC has made substantial achievement in restructuring and delayering initiatives. Progress in these areas is attributable to CDC's aggressive Strategic Management of Human Capital efforts, which includes delayering, position management, and consolidation. For Performance Measure 1, CDC's supervisory ratio improved from 1:6.8 in FY 2002, to 1:11.5 in FY 2004, thereby exceeding its target. In addition, the FY 2003 target for Performance Measure 2 was met. Measures 1 and 2 will be retired after data are reported for FY 2004 and 2003, respectively.

GOAL 3: RECRUIT AND RETAIN A HIGHLY QUALIFIED WORKFORCE.			
Performance Measure	Targets	Actual Performance	Ref
1. Use of above the minimum appointments to attract superior candidates.	FY 2004: 87 FY 2002: 81	FY 2004: 80 (Unmet) FY 2003: 52 FY 2002: 40 (Unmet)	-1
2. Use of recruitment bonuses for hard-to-fill positions.	FY 2004: 32 FY 2002: 29	FY 2004: 28 (Unmet) FY 2003: 28 FY 2002: 22 (Unmet)	-1
3. Use of retention allowances to retain essential employees.	FY 2004: 12 FY 2002: 9	FY 2004: 19 (Exceeded) FY 2003: 18 FY 2002: 3 (Unmet)	-1

Goal 3, Performance Measures 1 – 3:

CDC/ATSDR uses current human resource compensation authorities to help recruit and retain, such as “above the minimum” appointments, recruitment bonuses, and retention allowances. For Performance Measures 1 and 2, the FY 2004 targets were not met due to restricted employment during the period. For Performance Measure 3, the FY 2004 target was exceeded due to the need to retain current employees during a restricted employment period. These measures will be retired after data are reported for FY 2004.

COMPETITIVE SOURCING INITIATIVE

COMPETITIVE SOURCING PLAN


CDC developed a 10-year Competitive Sourcing plan to guide the program and the resulting studies each year. This plan reflects consideration of where and how competitive sourcing can best further the CDC's mission and maximize our savings potential.

STUDIES AND CONVERSIONS

CDC met its FY 2002 and FY 2003 Competitive Sourcing goals, as outlined by OMB. In FY 2003, CDC completed five studies of its Facilities Planning and Management Office. CDC prevailed in all five studies, indicating that through a rigorous and complex analysis of work, CDC was performing at a cost to the taxpayer less than that of comparable service providers. In FY 2004, CDC conducted five A-76 studies involving a range of CDC staff. The specific studies included (1) Animal Care, (2) Laboratory, Glassware and Associated Laundry Services, (3) Office Automation, (4) Printing, and (5) Materials Management. Again, except for the small printing streamlined study, CDC prevailed in each study, indicating that through a rigorous and complex analysis of work, CDC performs at a cost to the taxpayer less than that of other service providers.

During FY 2005, CDC will be completing a Library Services competition started in FY 2004. In addition, new competitions were announced for (1) Computer Clerk Support, (2) Statistical Support, and (3) Writer and Editor Services. These new FY 2005 competitions will include approximately 150 FTEs. CDC has also proposed to OMB, as an innovative alternative to an A-76 competition, the concept of developing a High Performing Organization for the Information Technology Services Office. This will allow CDC to achieve additional excellence in management services.

PERFORMANCE GOALS AND MEASURES

GOAL 4: PROVIDE VARIOUS STANDARDIZED AND INTEGRATED MEANS FOR ACCESS TO CDC INFORMATION RESOURCES BY HEALTH PRACTITIONERS AND THE PUBLIC.			
Performance Measure	Targets	Actual Performance	Ref
1. Increase the cost efficiency of providing IT infrastructure services across CDC. [E]	FY 2005: \$7,245/user/year	FY 2005: 12/2005 FY 2003: \$8,454/user/year	 - 2

Goal 4, Performance Measure 1:

CDC is improving service contracting effectiveness by increasing use of performance-based contracting for service contracts in alignment with administration and HHS goals. This measure will be retired after data are reported for FY 2005.

IMPROVED FINANCIAL PERFORMANCE INITIATIVE

ERRONEOUS PAYMENTS

As required by the Improper Payments Information Act, CDC is in the process of preparing the FY 2005 Risk Assessments for significant programs. The FY 2005 Risk Assessment for the Vaccines for Children program was submitted to the Department on November 23, 2004. In addition, CDC recently provided data files to the Recovery Auditing contractor. The contractor will use the data files to analyze transactions and identify high-potential transactions for audit. The on-site audit effort is scheduled to begin February 1, 2005.

UNIFIED FINANCIAL MANAGEMENT SYSTEM (UFMS)

The UFMS is being implemented to replace five legacy accounting systems currently used across the HHS Operating Divisions. The UFMS will integrate the Department's financial management structure and provide HHS leaders with a more timely and coordinated view of critical financial management information. The system also will facilitate shared services among the OPDIVs and help management substantially reduce the cost of providing accounting services throughout HHS. Similarly, UFMS, by generating timely, reliable, and consistent financial information, will enable the component agencies and program administrators to make more timely and informed decisions regarding their operations. As one of the five legacy accounting systems to be replaced, CDC is rolling out the UFMS (Oracle Federal Financials) into production in FY 2005.

With the implementation of UFMS, CDC will continue to pursue an aggressive strategy to upgrade fiscal management activities by bridging UFMS to the analytical and reporting tools necessary to respond to complex financial management requirements. These analytical and reporting tools will position CDC to respond to current, future and contingency financial management requirements. To accomplish this strategy, CDC has planned a multi-phased approach to UFMS. In October 2004, CDC implemented core UFMS Phase I. Core UFMS Phase I Implementation entailed deploying UFMS's General Ledger and Accounting for Pay Systems. In addition, CDC deployed the UFMS Interim Grants Solution in December 2004. This covered more than 50 percent of the dollar and transaction volume of the agency. The successful implementation of Phase I will be the cornerstone for future UFMS development and follow-up activities.

Phase II of UFMS will begin immediately at the beginning of FY 2005 with continuation into FY 2006. Phase II will entail multiple tasks to include movement of CDC to a fully project centric environment, modification of CDC feeder systems to support this environment, and development of a CDC data warehouse that will merge programmatic and financial information for meaningful management reporting. To this end, CDC commissioned and completed a business case to identify timelines, accurate cost estimates, preferred functional and technical solutions and a strategic plan to accomplish these efforts. The business case is currently under consideration. In addition to Phase II development, CDC will also need to plan for Phase I support. This will include continued funding to the HHS UFMS effort, post implementation support, and maintenance and support of non-Oracle systems. Full UFMS implementation is planned for April 2005.

CDC plans for \$3.368 million to be transferred as a reimbursement to HHS for core UFMS Program Management Office project support. CDC anticipates \$3.6 million to be used for on-going HHS UFMS operations and maintenance (O&M), software capitalization and amortization expenditures. CDC projects that an additional \$10 million is needed for Phase II development stages and Phase II completion of UFMS. CDC will spend a total of \$16.179 million to support the core UFMS project implementation, O&M, and the CDC multi-phased UFMS effort in FY 2006.

FINANCIAL MANAGEMENT IMPROVEMENT

CDC successfully began issuing quarterly financial statements in FY 2003. As a result, CDC closed its FY 2003 and 2004 accounting records on October 5, 2003 and October 7, 2004 respectively. CDC is also proceeding with its Financial Management Excellence Initiative to further improve financial operations by following guidelines set down by PricewaterhouseCoopers and the U.S. General Accounting Office in their separate November 2000 reports. For example, more than 169 employees are currently enrolled and 111 have graduated from CDC's Financial Management Certificate Program.

ACCOUNTABILITY

CDC participated in the HHS FY 2004 "top down" audit approach for which HHS received a clean opinion. Additionally, CDC received five consecutive clean audit opinions from FY 1998 through FY 2002 evidenced in the independent auditors' report in the CDC/ATSDR Chief Financial Officer's Annual Reports for the applicable years. CDC also performs management control reviews and risk assessments under the Federal Managers' Financial Integrity Act and reports results to HHS in an annual report.

In a continued effort to ensure the reliability and integrity of financial information and that the objectives for which funds are being expended adhere to Congressional Intent, a CDC base "Quality Assurance and Data Validation Team" has been established to regularly conduct internal financial assessments on randomly sampled data at the commitment and post obligation levels. Additionally this team will monitor compliance with laws, rules, and regulations.

EXPANDED E-GOVERNMENT INITIATIVE

CDC's budget includes funding to support the President's Management Agenda E-Gov initiatives and HHS enterprise IT initiatives identified through the HHS strategic planning process. Agency funds will be combined with resources in the Information Technology Security and Innovation Fund to promote collaboration in planning and project management, to achieve common goals such as secure and reliable communication, and lower costs for the purchase and maintenance of hardware and software. The enterprise IT investments enable HHS programs to carry out their missions more securely and at a lower cost. Examples of HHS enterprise initiatives currently being funded are Enterprise E-mail, Network Modernization, and Public Key Infrastructure (PKI).

ENTERPRISE ARCHITECTURE

CDC is playing a leading role in the establishment of a multi-departmental architecture for the President's Biosurveillance initiative. Agencies included are the Department of Homeland Security, the U.S. Department of Agriculture, the Department of Defense, the Environmental Protection Agency, the Food and Drug Administration, and the Homeland Security Council. CDC has made a major contribution to the HHS Enterprise Architecture and Federal Health Architecture efforts through the detail of the CDC Chief Architect to lead the HHS team for several months. Additionally, CDC has played a major contributing role to the development of the consolidated health informatics (CHI) standards and has led the development of many forerunning standards through the Public Health Information Network (PHIN) effort.

SECURITY

CDC continues to aggressively amplify its information security program, such as completing Certifications and Accreditations (C&A) on the 236 Federal Information Security Management Act critical systems by September 2004, conducting security assessments, security awareness training of all staff, and privacy impact assessments.

*HHS MODERNIZATION*Government-Wide E-Gov Projects

CDC is actively engaged in seven of the federal E-Gov initiatives, namely CHI, e-Vitals, e-Grants, e-Travel, Geospatial Information One Stop, SAFECOM, and GovBenefits, with an initial 16 CDC programs represented covering \$4.4 billion. CDC has actively advanced e-commerce using FedBizOpps to post all contract opportunities electronically. CDC is the leading agency for migrating to HHS' enterprise-wide grants management system, utilizing NIH's IMPAC II for research grants and ACF's GATES system for all other grants. CDC met the October 2003 goal for the Government Paperwork Elimination Act to make all information collections and disseminations available electronically.

Infrastructure Organization

CDC consolidated the agency's IT infrastructure functions, services, staff, and fiscal resources in accordance with OMB and HHS instructions. CDC has reduced costs by 21 percent (approximately \$23 million) and reduced staff by 18 percent in line with the overall agency reduction in mission support staffing. The 13 functions defined as IT infrastructure are: desktop computing support, directory services, e-mail, helpdesk support, infrastructure software, IT security, networking, data center services, office automation, remote access, server management, videoconferencing, and telecommunications.

Citizen-Centered Service

This past year, CDC launched its newly redesigned Web site. Key improvements include making the site more citizen-centered including improvements in use, navigation, searching, interactivity, personalization, and enriching and expanding content in a consumer-oriented presentation. CDC has one of the most frequently visited Web sites in the government as the authoritative trusted source of public health information for health care providers, public health officials, the media, and the public. CDC's web site attracts 10 million different visitors per month on average. The SARS outbreak resulted in over 17 million different visitors in April 2003.

BUDGET AND PERFORMANCE INTEGRATION INITIATIVE

CDC's efforts to integrate budget and performance have taken on increased significance as the agency works to implement a new strategy and organization under the Futures Initiative. Recently, the agency announced modernizations to enhance health impact, support the capacity to respond to public health emergencies, and to directly engage CDC's customers, the American public.

Across CDC, integration efforts are reflected in the development of the agency's Congressional Justification. This document aggregates performance information, required under the Government Performance and Results Act (GPRA), with budget information. The Congressional Justification reflects:

- An emphasis on outcome-oriented measures that demonstrate the focus of CDC's programs.
- Efficiency measures for nearly all programs, per OMB instruction via the Program Assessment Rating Tool (PART) review.
- Full costs calculated at the goal and performance measure level.
- Plans to address program deficiencies identified during PART reviews.
- Coordination across CDC throughout the development of the FY 2006 Congressional Justification and other integration activities.

SENIOR AGENCY MANAGER MEETINGS

Already, CDC's senior agency managers meet at least quarterly to discuss issues related to the direction of the agency. For example during the first quarter of FY 2005, a meeting for division directors addressed the pilot process for goals management, FY 2005 budget structure, and an update on public health research and business services. Quarterly meetings are planned for senior agency managers for the rest of the year to continue to inform and stimulate discussion and feedback on critical issues. As budget and performance integration continues to mature, CDC will establish a process for collecting information from senior agency manager meetings. This process will give the CDC an opportunity to report activities concerning budget and performance information.

PART

To date, 12 CDC programs (317 Immunization Program, Breast and Cervical Cancer, Diabetes, Domestic HIV/AIDS Prevention, HAN, ATSDR, State and Local Preparedness, B&F, Epidemic Services and Response, Occupational Safety and Health, Infectious Diseases, and STD/TB) have participated in a PART review by OMB. These programs have developed performance measures and follow-up plans, which are reported on in each submission of the Congressional Justification. Many of the performance measures are outcome-oriented and support the direction of the Futures Initiative. The follow-up plans address PART recommendations and provide a framework for making program improvements. During the first quarter, follow-up plans for the FY 2006 PART programs were developed.

The programs reviewed by PART have already seen improvements in strategy, program management and results. Improvements include:

- The 317 Immunization Program began an independent evaluation of the grant program and the collection of data to assess and improve business practices.

- A report of the first 12 years of the Breast and Cervical Cancer program was recently prepared and endorsed by the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) Federal Advisory Committee. This review was solicited as an independent verification of the effectiveness of the program in general.
- The Diabetes program completed a management analysis to determine how resources (i.e. human capital, time and funds) are being used to achieve National Program Objectives (NPO). The analysis successfully captured the internal and external influence, interaction and impact of resources.
- The Domestic HIV/AIDS Prevention program implemented the first phase of the Performance Evaluation Monitoring System (PEMS) to collect better performance data from grantees.
- ATSDR implemented a new long-term outcome measure for documenting the effectiveness of its interventions at sites that pose the most urgent public health hazards. ATSDR now evaluates its interventions at each site to determine their impact on public health. As a result, this new measure has focused the agency's leadership, its Cooperative Agreement Partners, and EPA on achieving public health outcomes.
- Outcome objectives and key performance indicators were developed for the Bioterrorism Cooperative Agreement Program and will be incorporated into the grant guidance for FY 2006.
- The Occupational Safety and Health program initiated a contract with the National Academy of Sciences to conduct a comprehensive evaluation of the impact and relevance of occupational safety and health research.
- The Infectious Diseases program plans to post performance data on the grantee profile pages, including FY 2004 funding, activities funded, links to the grantees home page, grantee contact information and FY 2004 Congressional summaries (available for a limited number of grantees).
- The TB program began to award state health department cooperative agreements for a new project cycle utilizing a new funding formula based on the burden of the disease.

During the first quarter, CDC facilitated a PART Debriefing meeting for the FY 2004 – 2005 programs to discuss challenges, identify best practices, share lessons learned, and find opportunities to improve the PART process. During the meeting, several of the programs identified open communication as a key element to success. As a result, CDC began to conduct monthly conference calls and distribute weekly emails to keep PART programs informed throughout the process.

Efficiency Measures

All CDC PART programs, including the five programs that were reviewed during the FY 2006 budget cycle, have or are developing at least one efficiency measure. These efficiency measures, along with their targets and actual performance, can be found in the FY 2006 Congressional Justification.

FULL COST

CDC continues to report the full costs calculated at the goal and performance measure level in the Congressional Justification. The full cost table has been changed to reflect changes from the Future's Initiative.

MARGINAL COST

CDC developed and pioneered a marginal cost methodology in conjunction with HHS. During the HHS Budget and Performance Training Day, CDC explained the criteria for program selection and current marginal cost activities. Currently, CDC is planning to disseminate the marginal cost methodology and hold a workshop to explain the marginal cost process.

ADMINISTRATIVE EFFICIENCIES - CDC BUSINESS SERVICES IMPROVEMENTS

To meet the challenges of today and the future, CDC has been involved in an extensive effort to increase the agency's health impact. The CDC Futures Initiative, as this effort is titled, has established six strategic imperatives that are the focus of reengineering CDC for the 21st Century. One of these six imperatives is "efficiency, effectiveness and accountability." As part of this strategic imperative, CDC is initiating major activities to enhance its business practices and services.

- To achieve this CDC vision of how well government should work by having more efficient and effective business practices to achieve greater health impact, CDC is in the process of consolidating or restructuring nearly 40 major business services. These actions will substantially improve CDC's business practices, while

at the same time, allow redeployment of resources from administrative and management functions to front-line public health activities. For example, through a broad range of consolidations and restructurings, the agency reduced its number of mission support (administrative) staff by almost 600 by January 2005. This reduction of over 15 percent of mission support staff will allow the redirection of staff positions to front-line public health efforts.

ESTIMATED SAVINGS ACTIONS

- CDC consolidated 13 information technology (IT) infrastructure functions, services, staff and fiscal resources into the new Information Technology Services Office (ITSO). This consolidation reduced operating costs by 21 percent (\$23 million) and staff by 18 percent.
- CDC consolidated the agency's medical and professional inquiry hotlines. CDC awarded a performance-based contract for consolidated public and professional health information services reducing more than 40 hotlines down to one. This will expand services (24x365, multilingual, hearing impaired) and save about \$35 million over 7 years.
- CDC completed the evaluation and detailed planning for budget execution services consolidation in FY 2004. In October 2004, CDC consolidated budget execution services across the agency. This action successfully resulted in a 20 percent reduction of staff working in budget execution services, or a decrease of 61 FTEs. In addition, cost savings are expected. Comprehensive Service Level Agreements are in place.
- CDC is evaluating vaccine purchase processes to streamline CDC's purchase of over half of the nation's childhood vaccines through its Vaccine Management Improvement Project.
- Competitive Sourcing Studies – Two Competitive Sourcing streamlined studies addressing 23 FTEs were completed. One competition for selected printing services determined an external source would be a lower cost, and the other determined the proposed "Most Efficient Organization" for materials management would operate at a lower cost. Specific savings will be compiled after the first full performance year.
- Competitive Sourcing Studies – CDC completed three standard studies in FY 2004, addressing nearly 200 FTEs. These studies were completed in August and September 2004, and associated FY 2005 savings will be compiled after the first full performance year; however, initial estimates indicate significant savings of more than \$30 million.

REDIRECTION OF RESOURCES

- CDC is taking the initiative in a number of consolidations and restructurings to redirect administrative positions to front-line public health positions. For example, CDC has reduced its level of mission support staff by approximately 600 staff, or over 15 percent, with follow-on redeployment to front-line public health duties, with more to follow in FY 2005.
- CDC has more than doubled its supervisory ratio. This is a classic measurement of flattening and layering an organization, which shows that fewer staff are involved in management or supervisory duties, and more staff are involved in actually conducting public health work. CDC's supervisory ratio has increased from 1:5.5 in 2001 to 1:12 in 2004.
- A complex and innovative approach to administrative/management consolidation was used to functionally merge the Office of the Director (OD) in both ATSDR and NCEH into one unit. FTE savings of 18 percent (35 FTEs) have already been realized.
- CDC is effectively completing its Business Services Consolidation Plan. This is an overarching strategy, approved by HHS in July 2003, to reduce administrative positions, centralize reporting and supervisory relationships, and establish agency-wide shared services.
- CDC, with HHS' guidance, completed the restructuring of its human resources office to the HHS Atlanta Human Resources Center (AHRC). This human resources office restructuring eliminated 76 FTEs, reflecting a 30 percent staff reduction. Despite this reduction, the time from AHRC's receipt of a hiring request to the day the job offer is made has been reduced by 47 percent, between 2003 and 2004.
- CDC consolidated administrative functions in about 30 CDC/OD offices, reducing staffing from a baseline of 83 FTEs to 63, or a savings of 24 percent. This action resulted in staff savings that can be redirected to mission direct activities.
- CDC completed the evaluation and detailed planning for consolidation of graphics services. Implementation of consolidated graphics services across the agency is expected to be complete in FY 2005. This action will

- result in fiscal and staff savings that can be redirected to mission direct activities, including savings expected from more efficient use of equipment.
- The Futures Initiative involves a range of evolving restructurings and efficiencies. For example, the CDC Director's span of direct reports was reduced from 23 to 15. In addition, in September 2004, CDC abolished two major program offices as part of the Futures Initiative. Staff from the two associated Offices of the Director have been redeployed within the new Coordinating Center for Health Information and Service, the new Office of Workforce and Career Development, or in other CDC programs.
 - The Office of Personnel Management has approved CDC/ATSDR's plan to offer Voluntary Separation Incentive Payments (VSIPs), or buyouts, to staff who work in mission support functions in 2005. Nearly 300 mission support staff have applied and been approved for these buyouts. CDC's plan is to use the VSIPs to help implement major reorganizations and business services consolidations which will result in significant business efficiencies and redeployment of positions to front-line public health efforts.
 - CDC has effectively used Voluntary Early Retirement Authority (VERA) to reduce mission support staff and restructure efficiencies accordingly. In FY 2003, 61 staff accepted VERA. In FY 2004, 36 staff accepted VERA.