

**DEPARTMENT  
of HEALTH  
and HUMAN  
SERVICES**

Fiscal Year  
**2008**

**Centers for Disease Control  
and Prevention**

*Justification of  
Estimates for  
Appropriation Committees*



## MESSAGE FROM THE DIRECTOR

As the Director of the Centers for Disease Control and Prevention (CDC) and the Agency for Toxic Substances and Disease Registry (ATSDR), I was proud to see the Agency through its 60<sup>th</sup> year, a milestone for the Agency and for public health. The world has changed drastically since CDC was founded in 1946, when the major threats to the public's health were infectious diseases. Today, we must continue to combat emerging and re-emerging infectious disease threats, as well as other urgent threats such as terrorism and pandemic influenza.

But our reality in the 21<sup>st</sup> Century also requires us to overcome complacency and address other urgent problems that we've come to accept: chronic disease, injuries, environmental and workplace hazards. I am committed to balancing CDC's portfolio by addressing both urgent threats and the urgent realities that threaten our health and well being.

I am pleased to present the fiscal year (FY) 2008 Congressional Justification and continue to appreciate the support and focus Congress places on promoting public health. As I reflect over the past five years, I am proud of the advancements we have made in preparing for urgent threats while continuing to combat urgent realities, such as the obesity epidemic and the dramatic increases in related conditions and costs. As I consider our investments, I stress the importance of Agency-wide health protection goals and the ability to direct investments to areas that demonstrate the greatest public health impact. We have made significant progress with our four health protection goals:

**People** – achieve optimal health during every life stage for all people, especially those at greatest risk for health disparities

**Places** – promote and protect health and safety in the places where people live, work, learn, and play

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

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

As CDC operates in an environment of increased fiscal accountability, the Agency's budget request reflects the federal focus on aligning budget decisions with programmatic performance data. The Agency recently implemented a new tool to link program performance and budget information. CDC will continue to use this tool in future years to better connect performance with the budget process.

CDC's FY 2008 budget request reflects the six strategic imperatives the Agency identified to support effective implementation of its goals. These strategic imperatives, along with the health protection goals, align with the priorities of both the President and Secretary of the Department of Health and Human Services (HHS), including the President's Management Agenda and the HHS FY 2005-2010 Strategic Plan.

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

This FY 2008 budget request highlights our accomplishments, conveys our vision, and reflects a strategic approach to FY 2008 that protects and enhances the public's health.

Sincerely,

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

Director, Centers for Disease Control and Prevention, and

Administrator, Agency for Toxic Substances and Disease Registry



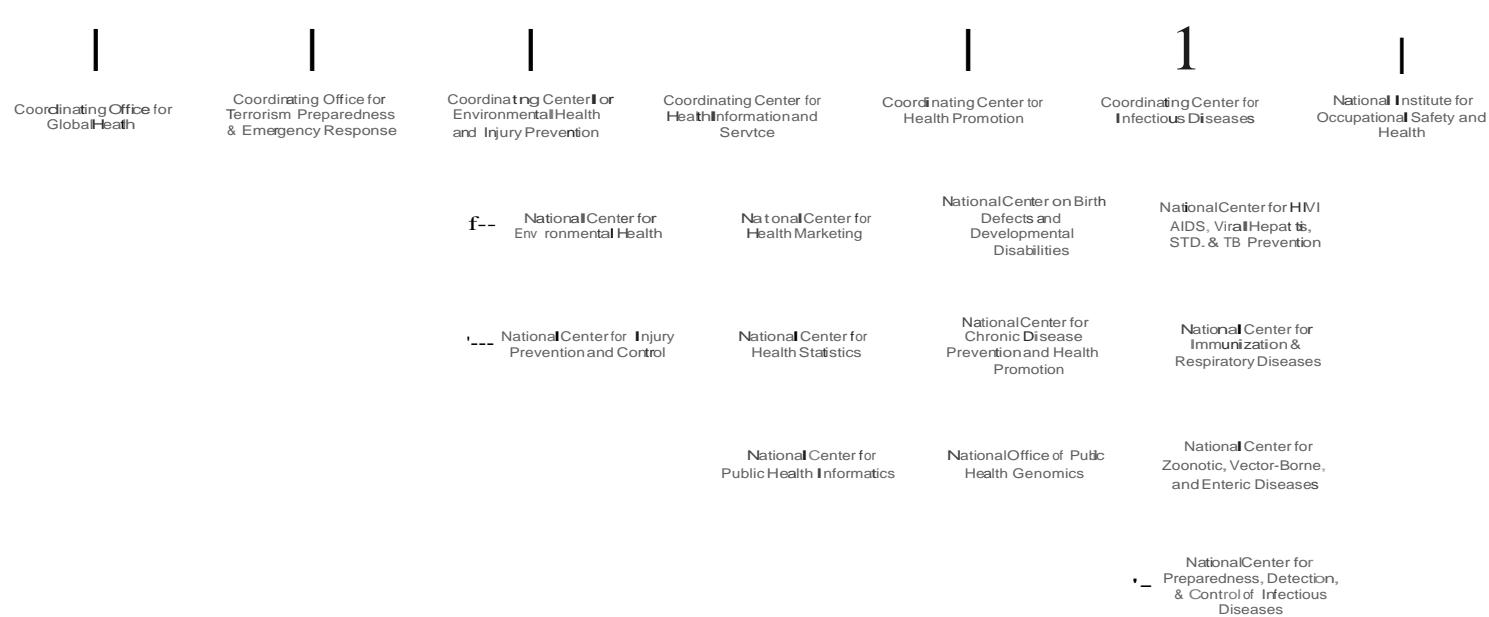
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## ORGANIZATIONAL CHART

PROPOSED

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

# **PERFORMANCE BUDGET OVERVIEW**

## STATEMENT OF MISSION

For the past 60 years, CDC has served as the leading public health agency in the United States and abroad. In response to the evolving public health challenges of the 21st century, CDC has broadened its approach to public health in order to address urgent health threats such as the spread of infectious diseases, terrorism, and natural disasters, in addition to urgent health realities such as chronic diseases, injuries, and environmental health. CDC based its restructured health protection efforts on fundamental health protection goals designed to accelerate health impact, reduce health disparities, and protect people from current and imminent health threats.

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

CDC serves people worldwide by working with diverse local, state, and international partners to prevent, monitor, investigate, and resolve the wide range of complex health issues facing the United States and global communities. In addition to addressing highly visible threats to the public's health like pandemic influenza, CDC also focuses on less sensational health realities, such as heart disease and obesity, which play an equally important role in achieving the best possible quality of life across the lifespan for the American public and global community. CDC is committed to addressing both urgent threats and urgent realities in order to protect people's health and safety, provide reliable health information, and improve health through strong partnerships. CDC continues to work towards a balanced portfolio which adequately addresses both the urgent threats and the urgent realities that threaten our health and well being.

CDC strives to base all public health decisions on the highest quality scientific data. The Agency's work directly supports the Secretary's 500-Day Plan for HHS and the Administration's priorities, transforming public health to ensure that its science and programs continue to secure the homeland, improve the human condition around the world, and protect the lives of Americans.

## DISCUSSION OF CDC STRATEGIC PLAN

CDC has refocused its efforts, reflected in its Health Protection Goals, to accelerate health impact, reduce health disparities, and protect people from current and imminent health threats. These goals are organized in four thematic areas – **Healthy People in Every Stage of Life, Healthy People in Healthy Places, People Prepared for Emerging Health Threats, and Healthy People in a Healthy World.**

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

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

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

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

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

Health Protection Goal Teams, led by CDC senior staff, are bringing together experts from inside and outside the agency to draft Goal Action Plans. Utilizing the best scientific evidence available, CDC's Goal Action Plans will include a prioritized set of objectives, recommended alignment of resources to accomplish objectives, and roles and responsibilities of organizational units across the agency with performance indicators to monitor progress. CDC's Goal Action Plans will bridge goals to more specific measures, strategies, and actions; integrate activities across CDC; identify opportunities for partner involvement and additional resources to accomplish the objectives; communicate with broad groups of stakeholders including the public; and cover a broad range of public health activities in which CDC might engage.

In FY 2006 and the beginning of FY 2007, CDC conducted a process to collect input at different events from partner organizations and the public on a set of "starter" objectives related to CDC's Health Protection Goals, and also on the draft criteria to be used in determining how to prioritize these objectives. In December 2006, the Goal Teams completed initial drafts of Goal Action Plans, which identified potential investments for the next three fiscal years that address the CDC Health Protection goals and objectives. The Health Protection Goal Teams will seek input and review from CDC's Division and National Center leaders, HHS, CDC's Advisory Committees and partners, and the public, before final action plans are approved. The Goal Action Plans will have an initial planning horizon of three fiscal years and will be refreshed annually as they continue to evolve, remain responsive to, and inform national priorities, emerging threats and public health needs, and the formulation and implementation of CDC's annual budget.

As always, CDC's program Divisions and National Centers will be responsible for planning and implementing activities and projects, overseeing their quality, and measuring their results. The goals action planning and implementation cycle is aligned with the federal budget cycle and CDC will continue to be guided by Administration and Congressional intent to be sure that categorical disease dollars target the appropriate activities. Over time, these health protection goals will allow CDC to objectively measure and demonstrate the impact of its health protection

activities and will inform the public, the Administration, Congress, partners, and stakeholders about the state of the public's health.

**Supporting Healthy People 2010 National Health Objectives:** CDC fully supports Healthy People 2010, and CDC's Health Protection Goals are designed to make CDC and our partners stronger contributors to the success of Healthy People 2010. The overarching Healthy People in Every Stage of Life and Healthy People in Healthy Places Goals directly support the goals and objectives for Healthy People 2010. Consequently, Healthy People 2010 measures will be used to support many of these objectives. The overarching People Prepared for Emerging Health Threats goals address crucial public health issues that are not priorities in Healthy People 2010. CDC is actively participating in HHS efforts to begin planning for Healthy People 2020. Through CDC's active participation in the planning for Healthy People 2020 objectives and the integration of Healthy People 2010 measures into our strategic Health Protection Goals Action Plans, CDC is strategically aligned with and responsive to the health objectives of the nation.

#### CDC's Health Protection Goals

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

- Start Strong: Increase the number of infants and toddlers that have a strong start for healthy and safe lives. (Infants and Toddlers, ages 0 - 3 years).
- Grow Safe and Strong: Increase the number of children who grow up healthy, safe, and ready to learn. (Children, ages 4 - 11 years).
- Achieve Healthy Independence: Increase the number of adolescents who are prepared to be healthy, safe, independent, and productive members of society. (Adolescents, ages 12 - 19 years).
- Live a Healthy, Productive, and Satisfying Life: Increase the number of adults who are healthy and able to participate fully in life activities and enter their later years with optimum health. (Adults, ages 20 - 49 years).
- Live Better, Longer: Increase the number of older adults who live longer, high-quality, productive, and independent lives. (Older Adults and Seniors, ages 50 and over).

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

- Healthy Communities: Increase the number of communities that protect and promote health and safety, and prevent illness and injury in all their members.
- Healthy Homes: Protect and promote health through safe and healthy home environments.
- Healthy Schools: Increase the number of schools that protect and promote the health, safety, and development of all students and the health and safety of all staff.
- Healthy Workplaces: Promote and protect the health and safety of people who work by preventing workplace-related fatalities, illnesses, injuries, and personal health risks.
- Healthy Healthcare Settings: Increase the number of healthcare settings that provide safe, effective, and satisfying patient care.
- Healthy Institutions: Increase the number of institutions that provide safe, healthy, and equitable environments for their residents, clients, or inmates.
- Healthy Travel and Recreation: Ensure that environments enhance health and prevent illness and injury during travel and recreation.

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

- Pre-event:
  - Increase the use and development of interventions known to prevent human illness from chemical, biological, radiological agents, and naturally occurring health threats.
  - Decrease the time needed to classify health events as terrorism or naturally occurring in partnership with other agencies.

PERFORMANCE BUDGET OVERVIEW  
DISCUSSION OF CDC STRATEGIC PLAN

- Decrease the time needed to detect and report chemical, biological, or radiological agents in tissue, food, or environmental samples that cause threats to the public's health.
- Improve the timeliness and accuracy of communications regarding threats to the public's health.
- Event:
  - Decrease the time to identify causes, risk factors, and appropriate interventions for those affected by threats to the public's health.
  - Decrease the time needed to provide countermeasures and health guidance to those affected by threats to the public's health.
- Post-event:
  - Decrease the time needed to restore health services and environmental safety to pre-event levels.
  - Improve the long-term follow-up provided to those affected by threats to the public's health.
  - Decrease the time needed to implement recommendations from after-action reports following threats to the public's health.

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

- Health Promotion: Global health will improve by sharing knowledge, tools, and other resources with people and partners around the world.
- Health Protection: Americans at home and abroad will be protected from health threats through a transnational prevention, detection, and response network.
- Health Diplomacy: CDC and the United States government will be a trusted and effective resource for health development and health protection around the globe.

**CDC's Six Strategic Imperatives**

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

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

### **LINKS TO HHS AND CDC STRATEGIC PLANS**

The table below illustrates links between CDC's overarching strategic goals and the HHS Strategic Plan.

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

## OVERVIEW OF PERFORMANCE

### HEALTHY PEOPLE AT EVERY STAGE OF LIFE

**Improving Detection of Breast and Cervical Cancer** – CDC's National Breast and Cervical Cancer Early Detection Program provides access to critical breast and cervical cancer screening for underserved women in the United States. To date, the program has screened almost three million women who otherwise would not have access to these critical cancer screening services. The program also has provided more than 6.5 million screening examinations and diagnosed almost 27,000 breast cancers, more than 88,000 mild to severe cervical precancerous lesions, and more than 1,700 invasive cervical cancers.

(Reference Detail of Performance Analysis for Chronic Disease Prevention, Health Promotion and Genomics: Goal 3, Performance Measure 1; 2006 PART measures: Goal 1, Performance Measures 2 and 3)

**Improving Cardiovascular Health in Women** – Well-Integrated Screening and Evaluation for Women Across the Nation (WISEWOMAN) provides screening and lifestyle interventions to low-income, under- or uninsured women in an effort to reduce risks for heart disease and other chronic diseases. During 2006, over 12,000 women were screened for a total of 77,500 women served since program inception. WISEWOMAN has provided more than 100,000 lifestyle interventions. For women who entered the program from 2000-2005, cholesterol levels dropped after one year from 211 to 206 milligrams per deciliter, and their estimated risk of heart attack in the next five years decreased. In the past four years, WISEWOMAN has identified more than 3,000 cases of previously undiagnosed hypertension, 3,600 cases of undiagnosed cholesterol, and more than 500 cases of undiagnosed diabetes.

(Reference Detail of Performance Analysis for Chronic Disease Prevention, Health Promotion and Genomics: 2006 PART measures: Goal 4, Performance Measures 2 and 3)

**Access to Tobacco Cessation Services:** More Americans have access to effective tobacco-use cessation services than ever before. Through the National Network of Tobacco Use Cessation Quitlines, 50 states and five jurisdictions have active quitlines. Last year, through CDC's collaborative efforts, the Centers for Medicare and Medicaid Services (CMS) added smoking cessation counseling as a benefit for Medicare recipients. CDC successfully collaborated with the Office of the Surgeon General to release *The Health Consequences of Involuntary Exposure to Tobacco Smoke, A Report of the Surgeon General*, the most comprehensive and most authoritative scientific report yet issued on the health risks of secondhand smoke.

(Reference Detail of Performance Analysis for Chronic Disease Prevention, Health Promotion and Genomics: 2006 PART measures: Goal 2, Performance Measures 2)

**Preventing and Controlling STDs** – In 1999, CDC launched its National Plan to Eliminate Syphilis from the United States. Prevention and control activities focus on the populations most affected by syphilis. In 2005, the reported rate of primary and secondary syphilis among females declined 55 percent from the reported rate in 1999, and the reported rate of congenital syphilis declined 45 percent in the same time frame, from 14.6 cases per 100,000 live births in 1999 to 8.0 cases per 100,000 births in 2005. Progress has also been made in reducing syphilis-related health disparities. The black to white syphilis reported ratio decreased from 43: 1 in 1997 to 5.4:1 in 2005.

(Reference Detail of Performance Analysis for HIV/AIDS, Viral Hepatitis, STD and TB Prevention: Goal 7, Performance Measures 1 and 2; Goal10, Performance Measures 1 and 3)

**Improving HIV Screening - Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings** – One quarter of HIV-infected Americans are unaware of their infection and about 40 percent of those who are diagnosed with HIV receive an AIDS diagnosis less than a year later, revealing missed opportunities to prevent transmission and protect the health of those who are infected. CDC has published new recommendations for health care providers that are designed to make voluntary HIV screening a part of medical care for all patients aged 13 to 64. The recommendations aim to simplify the HIV testing process in health care settings and increase early HIV diagnosis among the estimated more than 250,000 HIV-positive Americans who are unaware of their infection. CDC supported the released recommendations with pod casts, satellite broadcasts, and meetings with policy-makers and providers. Several major insurers have announced their willingness to cover recommended HIV testing for their insured populations.

(Reference Detail of Performance Analysis for HIV/AIDS, Viral Hepatitis, STD and TB Prevention: Goal 3, Performance Measure 1)

**Decreasing Adolescent Risk Behavior** – Prevention activities targeted at adolescents provide young people with skills and information to help them avoid behaviors that put them at risk for serious health problems such as asthma, heart disease, and HIV infection. CDC supports state and local education agencies in their efforts to provide effective health education targeted at youth, including minority races and ethnicities. CDC currently supports HIV prevention through school health programs in 48 states, 7 territories, and 18 large city education agencies. Between 1991 and 2005, the percentage of students who used a condom at last sexual intercourse increased from 46 percent to 63 percent and the percentage who had been taught about HIV and AIDS in school increased from 83 percent to 88 percent. In addition, the proportion of fully tobacco-free secondary schools increased from 37 percent in 1994 to 46

percent in 2000. A large 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 23 percent in 2005.

(Reference Detail of Performance Analysis for Chronic Disease Prevention, Health Promotion and Genomics: Goal 5, Performance Measure 1, Goal 7, Performance Measure 1; 2006 PART measures: Goal 1, Performance Measures 1, 2 and 4)

**Preventing Developmental Delays – Early Detection and Intervention of Autism** – Early detection of young children with an autism spectrum disorder (ASD) can lead to participation in interventions that support developmental outcomes. In May 2006, CDC published the first parental report study of diagnosed autism in children ranging from 4-17 years old in the United States, suggesting that over 300,000 school-aged children had autism in 2003-2004. In April 2006, CDC published a study addressing the time between the first evaluation and first autism diagnosis, suggesting that practitioners lack the use of standardized tools and instruments for diagnosis. In order to train both parents and professionals, CDC has taken an active role in promoting early screening and intervention for children with autism through the health promotion campaign “Learn the Signs. Act Early.” The campaign has reached over 3 million health care professionals and distributed over 14,000 professional resource kits. Over 20,000 parent information kits have been distributed, and more than 30,000 materials have been downloaded from the campaign website.

**Delivering Cost Effective Immunizations** – Public health action saved \$43.3 billion through seven vaccines. An economic evaluation of the impact of seven vaccines (tetanus, diphtheria, and pertussis; tetanus and diphtheria; haemophilus influenza type B; poliomyelitis; measles, mumps, and rubella; hepatitis B; and varicella) routinely given as part of the childhood immunization schedule found that vaccines are tremendously cost effective. Childhood vaccination with the seven tested vaccines, which prevent more than 14 million cases of disease and over 33,000 deaths over the lifetime of children born in any given year, resulted in annual savings of \$9.9 billion in direct medical costs and over \$33.4 billion in indirect societal costs. This study, published in the *Archive of Pediatrics and Adolescent Medicine*, is the first time the seven vaccine series has been examined together with a common methodology.

(Reference Detail of Performance Analysis for Immunization and Respiratory Diseases: Goal 2, Performance Measure 1)

## **HEALTHY PEOPLE IN HEALTHY PLACES**

**Maintaining Healthy Homes** – Childhood lead poisoning, unintentional home injuries, asthma and allergic episodes from dust mites, pets, mold, and exposures to rats, mice, and cockroaches have a significant impact on health and well-being. In collaboration with the Department of Housing and Urban Development's (HUD) Office of Healthy Homes and Lead Hazard Control, CDC has developed a National Healthy Homes Training Center and Network. The center provides training for practitioners in the assessment and treatment of housing related health hazards. More than 300 nurses, environmental health, public health, and housing specialists were trained at 10 different locations in 2005. In partnership with HUD, CDC produced and distributed and updated Healthy Housing Reference Manual, a resource designed to be used by local health, environmental health, and housing departments to provide comprehensive recommendations to make homes healthier and safer. Some of the public health issues addressed by the manual include indoor air pollution, rodents and other disease vectors, waste water disposal, and lead poisoning prevention.

**Preventing Residential Fire Deaths** – A review of homes participating in CDC-funded smoke alarm installation and fire safety education programs found that approximately 1,164 lives have been saved to date. Program staff have canvassed over 402,000 homes and installed more than 295,000 long-lasting or lithium-battery powered smoke alarms in high-risk homes, specifically those with children ages five years and younger and adults ages 65 years and older. Through both the year-round promotion of the program in each community (e.g., local radio, television, newspapers, church bulletins, health clinics) and the education and smoke alarm installations that occur in each participant's home, fire safety activity and messages have reached the individuals and populations in greatest need.

(Reference Detail of Performance Analysis for Injury Prevention and Control: Goal 1, Performance Measure 2, Goal 5, Performance Measure 1)

**Detecting Environmental Exposures** – CDC supported 30 environmental public health tracking assessments examining the possible association between a health effect and an environmental exposure or hazard. These data led to 17 public health actions. For example, the Massachusetts Tracking Program found a statistically significant association between the presence of moisture problems in a school and the prevalence of asthma in schoolchildren. This association indicated the need for public health follow-up and intervention, and provided information for policy changes. CDC is working with school officials to identify how to remediate the moisture problems. Such efforts are helping enhance the National Environmental Public Health Tracking Network.

(Reference Detail of Performance Analysis for Environmental Health: Goal 1, Performance Measure 2)

**Improving Coal-Mining Safety** – CDC and its partners received the prestigious R&D 100 Award in 2006 for development of the “Coal Dust Explosibility Meter – Model 100.” This is the first device created to immediately determine if coal dust concentrations in active areas of underground coal mines have been sufficiently mixed with rock dust to prevent risk of explosion. Technologies currently used to assess coal dust concentrations require lab analysis that may take as long as two weeks to complete. The explosibility meter can be used to avoid this delay and enhance mine safety.

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

**Detecting Methamphetamine Exposure** – CDC and its partners developed a new method for detecting methamphetamine (meth) contamination to rapidly identify toxic exposures of police officers assigned to seize illegal meth labs. In 2005 alone, there were over 12,000 incidents in the United States involving meth labs. Significant occupational risks of exposures to toxic materials exist for those entering sites contaminated with chemical wastes from meth production. The new meth wipe method provides faster and lower-cost identification of meth contamination on surfaces and allows decisions on safe procedures and protective clothing for officers and other personnel to be made quickly. With the new method, results can be available in minutes compared with days for traditional methods.

**Eliminating Childhood Lead Poisoning** – CDC made advancements by providing technical assistance to states not receiving grants for addressing childhood lead poisoning. The program’s work with Mississippi resulted in the first ever submission of Mississippi blood lead surveillance data to CDC and allowed for CDC to help in developing the state’s strategic plan for elimination of childhood lead poisoning.

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

## **PEOPLE PREPARED FOR EMERGING HEALTH THREATS**

**Responding to Public Health Threats** – Between October 1, 2005 and September 30, 2006, headquarters Epidemiologic Intelligence Service (EIS) officers responded to 79 requests for assistance with epidemiologic field investigations from 31 states and 15 countries. Additionally, field EIS officers assigned to state and local health departments conducted 374 epidemiologic field investigations in 47 states and 8 countries. Requests for assistance were primarily for infectious disease problems but also addressed environmental health, injuries, and maternal and child health.

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

**Increasing Surveillance Capacity** – CDC established and improved the capacity of domestic and global sentinel surveillance networks linking health care providers in order to improve the ability to detect and monitor emerging diseases. These networks include: sentinels along the United States - Mexico border; sentinel physicians for influenza; travel medicine clinics in the United States and other countries; academic hospital emergency departments; and infectious disease specialists throughout the United States. These networks are capable of identifying and responding to emerging infections that require immediate attention. In addition, through CDC’s Select Agent and Toxins Program, CDC initiated the investigation of all thefts, losses, and releases of select agents or toxins within five days of receipt of report. The program also developed and tested a national Select Agent database and system that will provide a single source for registration, transfer, amendments, inspection data, and other required information.

(Reference Detail of Performance Analysis for Preparedness, Detection, and Control of Infectious Diseases: Goal 3, Performance Measure 1)

**Enhancing the Laboratory Response Network (LRN)** – CDC has increased the number of LRN labs to 152, up from 91 in 2001. This number includes food and veterinary labs, allowing for greater ability to detect threat agents in the nation. These labs are now located in all 50 states and several international locations. Of the labs funded through the 2006 cooperative agreement, 100 percent can confirm anthrax, tularemia, and plague and more than 90 percent can confirm melioidosis, ricin toxin, staphylococcal enterotoxins, SARS virus, non-variola orthopox, and influenza A/H5. CDC has trained more than 9,000 clinical laboratorians to play a role in the detection, diagnostics, and reporting of public health emergencies.

(Reference Detail of Performance Analysis for Terrorism: Goal 4, Performance Measure 2)

**Ensuring the Safety of Respirators for Emergency Responders – Respirator Certification** – CDC continues to conduct a respirator certification program to ensure respiratory protective equipment conforms to established regulatory standards. The agency issued 402 approvals in 2006 including 30 respirators for occupational use by emergency responders against CBRN (Chemical, Biological, Radiological and Nuclear) agents. Of these 30, 11 were self-contained breathing apparatus (SCBA), 10 air-purifying respirators, and nine air purifying escape respirators. CDC has initiated testing for Powered Air Purifying CBRN respirators with three applications in process. In addition, CDC is installing a CBRN laboratory respiratory protection level testing chamber to improve the timing and decrease the cost of testing. CDC has also significantly decreased the approval times for new N95 respirators to increase the availability of filtering facepiece respirators.

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

**Developing Influenza Vaccine** – A critical aspect of influenza pandemic preparedness is vaccine development. CDC has developed several candidate H7N7, H7N2, and H5N1 pandemic vaccines to meet pandemic preparedness goals. The H7N7 and H7N2 candidate vaccines were part of the public health preparedness response to the outbreaks of avian H7 viruses in poultry, which caused human infections in Canada and the Netherlands, the latter involving one fatality. The H5N1 avian influenza outbreak in Asia, Europe, and Africa has caused more than 250 infections and in excess of 150 deaths. Vaccination is one of the major public health interventions if the virus becomes pandemic.

**Enhancing Preparedness at Ports of Entry** – As of September 2006, CDC increased its number of quarantine stations at international ports of entry into the U.S. to 20. By September 2007, Emergency Response Plans will be drafted and integrated with local quarantine system partners at 18 ports of entry. CDC is continuing to enhance the CDC Quarantine Network through expanded field presence, community partnership, preparedness and response activities, and increased surveillance and epidemiologic research. Quarantine station expansion and enhancement has improved the systematic collection, analysis, interpretation, and dissemination of data related to public health events at U.S. ports of entry. This improves CDC's capacity to respond to natural and intentional communicable disease emergencies of public health significance.

(Reference Detail of Performance Analysis for Terrorism: Goal 5, Performance Measure 2)

**Delivering Bioterrorism Preparedness Training** – In FY 2006, CDC staff administered three “Agents of Bioterrorism: Train-the-Trainer for the LRN Sentinel Laboratory” courses in California, New Hampshire, and New Jersey. The online course “Bioterrorism Preparedness Training for LRN Sentinel Laboratories,” a joint project with the Microbial Disease Lab of the California Department of Health Services, has added a sixth module on the bacteria, Burkholderia. More than 2,000 laboratorians from 49 states have accessed this course. Over 6,250 participants received training in Pandemic Influenza Preparedness.

## **HEALTHY PEOPLE IN A HEALTHY WORLD**

**Eradicating Global Polio** – CDC provides epidemiologic, laboratory, and programmatic support for global polio eradication and works with partners from World Health Organization (WHO), Rotary International, and The United Nations Children's Fund (UNICEF) as part of the Global Polio Eradication Initiative. Global polio incidence has declined from approximately 350,000 cases in 1988 to 1,791 cases in 2006. Since 1988, roughly 250,000 lives have been saved and five million cases of childhood paralysis avoided. Today, more than 200 countries and territories are polio free and the disease is now endemic in only four countries in the world: Nigeria, India, Pakistan and Afghanistan. In 2006, more than 94 percent of all cases detected globally have been from these four countries, with 58 percent from Nigeria and 33 percent from India alone. In 2006, CDC participated in development of new laboratory procedures which can detect and confirm new polio infection twice as quickly, enabling a more rapid outbreak response.

(Reference Detail of Performance Analysis for Global Health, Global Immunizations: Goal 4, Performance Measures 1 and 2)

**Preparing for Avian Influenza** – In FY 2006, CDC placed staff in strategic oversees positions to coordinate avian influenza activities and provide on-going technical assistance to improve international pandemic preparedness. Onsite outbreak assistance, technical assistance, or training was provided to China, Vietnam, Thailand, Indonesia, Nigeria, Turkey, Brazil, Laos, Cambodia, Ukraine, Kenya, Uganda, Kazakhstan, Egypt, Djibouti, and Romania for avian influenza outbreaks. In addition, CDC developed the first H5N1 Clade 2 pandemic influenza vaccine candidate for distribution to vaccine manufacturers, advanced development of a rapid influenza diagnostic test, and collaborated with partners within and outside of CDC to identify and promote health behaviors (e.g., hand hygiene, cough etiquette, and respiratory hygiene) that can prevent the spread of influenza and other respiratory infections.

(Reference Detail of Performance Analysis for Immunization and Respiratory Diseases: Goal 4, Performance Measure 1)

**Improving Global Disease Detection (GDD) Efforts Worldwide** – CDC's GDD program works with international partners to protect Americans from infectious disease threats. This is accomplished through efforts ensuring rapid and accurate detection, promoting diagnosis and verification of global emerging infectious diseases and bioterrorist threats, and controlling infectious diseases at their origin to prevent international spread. The initial focus of the GDD program has been strengthening the global influenza surveillance network through bilateral support to 12 countries and enhanced communications and laboratory capabilities in five strategic countries (Thailand, Kenya, Guatemala, China, and Egypt). In 2006, CDC investigated more than 60 disease outbreaks, including cases of avian influenza, hemorrhagic fever, meningitis, cholera, and unexplained sudden death through established GDD Response Centers in Kenya, Thailand, China, Guatemala and Egypt.

(Reference Detail of Performance Analysis for Immunization and Respiratory Diseases: Goal 4, Performance Measure 1)

**Decreasing Measles Related Mortality Worldwide** – Measles is the leading cause of childhood deaths from a vaccine preventable disease, causing an estimated 530,000 deaths globally since 2003. CDC and partners in the Measles Initiative support the WHO's 47 priority countries and the Global Immunization Vision and Strategy Goal of reducing global measles death by 90 percent by 2010. CDC and partners met the World Health Assembly endorsed goal to reduce global measles-related mortality by 50 percent between 2001 and 2005. Measles mortality in the African region has been reduced by 74 percent since 1999 and measles mortality worldwide has been reduced 60 percent. The goal was achieved ahead of schedule and under budget by immunizing over 200 million children in 33 countries and saving over a million lives since mid-2001. In addition, the number of measles cases in the Western Hemisphere has been reduced by more than 99 percent, from approximately 250,000 cases in 1990 to 186 (all associated with imported viruses) provisionally reported in 2006.

(Reference Detail of Performance Analysis for Global Health, Global Immunizations: Goal 5, Performance Measures 1 and 2)

**Contributing to International AIDS Relief** – In 2006, CDC provided technical assistance and support for programmatic activities (e.g., prevention, laboratory capacity, surveillance and Prevention of Mother-to-Child Transmission (PMTCT), care and treatment) in 29 Global Aids Program (GAP) countries. In addition, GAP assigned over 100 CDC staff to the field and employed over 1,000 local staff to implement country programs. As of September 2006, CDC supported the President's Emergency Plan for AIDS Relief (PEPFAR) in providing life-saving antiretroviral treatment for approximately 822,000 men, women and children through bilateral programs in PEPFAR's 15 focus countries in sub-Saharan Africa, Asia and the Caribbean. CDC supported PEPFAR in providing antiretroviral prophylaxis for women during 533,000 pregnancies, preventing an estimated 101,500 HIV infections. As of September 2006, CDC provided 18.7 million counseling and testing sessions for men, women, and children and provided HIV care for nearly 4.5 million individuals.

(Reference Detail of Performance Analysis for Global Health, Global AIDS Program: Goal 2, Performance Measures 1, 2, 3, and 4)

**Preventing Malaria in Children** – CDC collaborated with Roll Back Malaria partners on the development of the African Strategic Framework for Malaria Prevention in Pregnancy and provided financial support or technical assistance for malaria program implementation in 14 countries and 7 regional networks in Africa. CDC provided 87 on-site technical consultations to 24 countries and numerous partner organizations on malaria-control activities and implementation of research projects. In partnership with USAID, CDC provided new assessments and strategic planning with the national malaria control programs in the President's Malaria Initiative to Senegal, Mozambique, Rwanda, and Malawi and continued to support implementation and evaluation in Angola, Uganda, and Tanzania.

## OVERVIEW OF BUDGET REQUEST

The FY 2008 President's Budget reflects CDC's commitment to urgent threats and realities by investing new and existing funding in high priority activities that span the agency's mission. The FY 2008 President's Budget request reflects a total funding level of \$8.8 billion, which reflects a decrease of \$162.6 million below the FY 2007 Continuing Resolution of \$9.0 billion. Within the total funding level, CDC has balanced increased investments with targeted program reductions to approach the FY 2008 President's Budget with fiscal responsibility. The FY 2008 request balances funding for urgent threats, such as protecting against emerging infectious diseases, with funding for urgent realities, such as the prevention of chronic diseases.

CDC continues its strong commitment to advancing the field of public health and accelerating health impact by focusing its efforts on a balance between urgent threats and urgent realities. Currently, CDC executes and tracks hundreds of budget lines, corresponding with program activities across the agency. Reduced direction at this detailed level would increase CDC's ability to address programmatic and scientific areas using a more coordinated, science-based approach to addressing broader public health issues. CDC seeks a more simplified FY 2008 budget with fewer budget levels set by Congress. CDC will continue to be accountable for health impact in major priority areas, as determined by Congress.

### **Pandemic Influenza Preparedness (+\$158.3 million)**

Pandemic Influenza is a major priority in the FY 2008 President's Budget, as preparedness for a pandemic is critical for ensuring the health and safety of the nation. The requested \$158.3 million will enhance activities begun in FY 2006 with two supplemental appropriations and will begin additional preparedness activities.

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

CDC will increase demand for influenza vaccine by providing funds to States and through communication activities. CDC will increase the demand for and uptake of annual influenza vaccine, particularly to accommodate high-risk populations. Increasing vaccine demand will stimulate vaccine manufacturers to produce additional vaccine, thereby increasing vaccine production capacity and helping the nation's preparedness for a pandemic.

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

Increased funding will allow CDC to increase laboratory and analytical capabilities for genetic and antigenic analysis of influenza vaccines.

#### Increase stock of Diagnostic Reagents for Influenza (+\$14.9 million)

With increased resources in FY 2008, CDC will provide for acquisition, storage, shipping, and support of a newly acquired inventory either internally or through a commercial vendor. CDC will also work with the manufacturer to work toward more stringent quality assurance and control by instituting control protocols to ensure reagents are used properly. Finally, CDC will provide incentives for the manufacturer to make reagents available when needed.

#### Vaccine Registry (+\$14.6 million)

CDC will use funding of \$14.6 million in FY 2008 to develop and deploy national capabilities to track and manage the distribution of influenza vaccine and other countermeasures through government purchase, commercial purchase, or stockpile from the point of manufacture through the administration of vaccine to recipients. CDC will also integrate such information with adverse event monitoring and surveillance tracking.

#### Real Time Assessment and Evaluation of Interventions (+\$9.9 million)

With increased funding in FY 2008, CDC will improve decision makers' abilities to understand the current disease burden, develop predictions, and integrate key surveillance data by enhancing system capabilities in three key ways: 1) collect and collate all suitable existing influenza-related surveillance data from various systems to develop a population-based analysis of disease impact and evaluation of interventions; 2) design and implement robust models that will use these data to provide frequently updated population-based estimates of disease burden and impact of interventions; 3) create decision tools based on these data and usable by decision makers at local, state, and national levels.

**Rapid Outbreak Response for High Priority Countries (+\$17.8 million)**

When a potential pandemic influenza strain is identified, swift and decisive action can make the difference in whether the strain is contained or spread globally. Based on the available epidemiologic information, CDC will continue to identify countries at high risk for the emergence of a potential pandemic and in need of monitoring efforts and help develop in-country response teams. Funds in the FY 2008 President's Budget will allow CDC to enhance activities undertaken with funding in FY 2006 to ensure that target countries are monitored and safeguarded from disease spread that could elevate to pandemic levels.

**Human-Animal Interface Studies (+\$4.0 million)**

To complement National Institutes of Health epidemiological studies, CDC will continue to support studies that examine the risk and frequency of human infections with animal influenza A viruses that have pandemic potential through the FY 2008 President's Budget. CDC will analyze epidemiologic case control studies of risk factors for severe disease and cross sectional seroprevalence studies of antibodies of H5N1 virus in different risk populations that may include people with occupational exposure to poultry and persons living in rural areas with, or in close contact with, poultry and pigs.

**International Surveillance, Diagnosis, and Epidemic Investigations (+\$47.5 million)**

With increased funding in FY 2008, CDC will enhance its efforts to address these preparedness gaps through increasing laboratory capacity and technical support at local levels; assisting in the development of surveillance, diagnosis, and epidemic investigations; and assisting the WHO in creating and maintaining proper coordinating and monitoring infrastructure in high risk countries.

**Quarantine Stations (+\$10.0 million)**

Increased funding of \$10 million in FY 2008 will be used to support up to 25 stations in FY 2008.

**Increased Investments (+\$209.7 million)**

**Adolescent Health Promotion Initiative (+\$17.3 million)**

CDC is requesting \$17.3 million to support Secretary Leavitt's Adolescent Health Promotion Initiative, which aims to create a national culture of wellness that helps individuals take responsibility for personal health through actions such as regular physical activity, healthy eating, and injury prevention. Schools can play a critically important role in fostering a culture of wellness by teaching children and adolescents essential knowledge and skills for healthy eating, physical activity, and safety. The Adolescent Health Promotion Initiative will establish a culture of wellness in schools through implementation of HHS's School Health Index. Upon completing the physical activity and nutrition modules of the School Health Index self-assessment process, schools will be able to apply to their State Education Agency for a School Culture of Wellness Grant. Approximately 3,600 Culture of Wellness Schools will be funded around the country to help schools implement HHS-developed tools relevant to wellness improvements. This program will enable thousands of local schools to take full advantage of HHS's science-based resources and begin to halt the epidemic of childhood obesity plaguing our nation.

**HIV/AIDS Testing (+\$93.0 million)**

CDC is requesting a total of \$93 million for HIV/AIDS testing. Of the total increase, \$63 million is requested to support testing programs primarily in 10 jurisdictions with the greatest rates of new infections, as well as focusing on incarcerated persons and injecting drug users. CDC estimates that over 2 million Americans, mostly African-Americans, will be tested and over 31,000 new infections will be diagnosed. Additionally, the 40% of those diagnosed who would have progressed to AIDS within a year will learn of their infection earlier as a result of this initiative. They will have the opportunity to stay in better health longer, resulting in decreased overall cost to the health care system. This effort is expected to avert 1,500 infections in the first year alone, thereby saving \$1.5 billion in annualized medical care and lost productivity costs. In addition, \$30 million is requested to implement the Early Diagnosis Grant Program authorized in the Ryan White HIV/AIDS Treatment Modernization Act of 2006 (PL 109-415). The statute requires CDC to designate \$20 million of its HIV prevention funds for states with policies supporting voluntary opt out testing of pregnant women and requiring universal testing of infants. It also requires CDC to designate \$10 million for states with policies in effect supporting voluntary opt-out testing for clients at STD clinics and drug treatment centers.

### **Improving Special Pathogens Laboratory Capacity (+\$5.2 million)**

Infectious diseases continue to threaten our nation's health and the health of individuals worldwide. Although great strides have been made toward preventing and controlling infectious disease, it remains clear that a disease emerging in one country can rapidly lead to problems around the globe. CDC is well-known for its state-of-the-art maximum and high containment laboratories, in which scientists can work with highly pathogenic viruses and bacteria, and its integration of this laboratory capacity with subject matter and epidemiologic expertise. CDC's leadership in this area has made the agency a highly sought-after resource for countries seeking assistance. Increased funding for CDC's laboratory capacity in FY 2008 will build the agency's basic science program for high hazard pathogens, the cadre of scientists that populate it, and its capacity for outbreak response.

### **Strategic National Stockpile (+\$89.9 million)**

The Strategic National Stockpile (SNS) permits CDC to respond to mass trauma events by delivering medical supplies to any point in the United States within 12 hours. Following review of response to the Gulf Coast Hurricane season of 2005, the formulary of the Federal Medical Stations (FMS) was updated to include selected pharmaceuticals and special needs items that were required to successfully support the response. Increased funds will allow the SNS to include these updated items and ensure that the SNS is equipped to best meet the nation's public health emergency needs.

### **National Home and Hospice Care Survey (+\$0.9 million)**

Funding requested for FY 2008 will be used for fielding the redesigned National Home and Hospice Care Survey (NHHCS), the first since 2000. The NHHCS is a continuing series of surveys of home and hospice care agencies in the United States. Information was collected about agencies that are licensed or certified by Medicare or Medicaid. Data are collected through personal interviews with administrators and staff on referral and length of service, diagnoses, number of visits, patient charges, health status, reason for discharge, and type of services provided.

### **Pay Raise (+\$3.3 million)**

The FY 2008 President's Budget includes a pay raise of \$3.3 million for Business Support Services and Public Health Improvement and Leadership. Increased funding for the pay raise is a critical component of CDC's budget, as it allows programs to continue funding extramural and intramural science programs without the need to absorb the increased pay costs at the expense of these programs. Increased funding will also support ongoing services maintained by CDC's business service units and expansion into new business areas that are critical to the success of the agency. As CDC's science and business staff conduct critical activities and oversee the implementation of the nation's public health programs funded by CDC, increased funding to support pay is a necessary component of enhancing the health of the nation.

### **Agency for Toxic Substances and Disease Registry (+0.1 million)**

The FY 2008 Budget of \$75 million for Agency for Toxic Substances and Disease Registry (ATSDR) represents an increase of \$0.1 million over the FY 2007 Continuing Resolution. Increased funding will be used for ATSDR's state cooperative agreement to develop environmental health capacity, provide health education, and conduct health outcome data reviews related to potential exposures to hazardous substances and toxic chemicals.

### **Program Reductions and Eliminations (-\$530.5 million)**

#### **Steps to a HealthierU.S. (-\$17.3 million)**

Steps to a HealthierU.S. was funded for the first time in FY 2003 as a mechanism to assist 40 communities, cities, and tribal entities in implementing community action plans that build on existing local, state, and federal efforts related to obesity, diabetes, asthma and their risk factors. In addition, the plans include a special focus on populations with a disproportionate burden of disease and disparities in preventive services. Through the Steps program, organized community, environmental, educational, media, and policy interventions are being implemented in school, community, healthcare and workplace settings. The Steps program establishes an alliance of partnerships and coalitions committed to participating actively in planning, implementation, and evaluation activities. These partnerships track specific indicators of progress in conjunction with quantifiable program objectives. CDC is currently assessing experiences, successes, and lessons learned from the first Steps communities in order to inform future directions, especially in the area of how to achieve broader impact. With a decrease of \$17.2 million in FY 2008, the Steps programs that end their five year cycle will not be continued. Funding will be continued for the 13 programs that have not yet completed their five year cycle.

**West Nile Virus (-\$16.9 million)**

CDC has awarded funds to 57 state, local, and territorial public health agencies to assist in the development of comprehensive, long-term disease monitoring, prevention, and control programs for WNV. WNV funding has built infrastructure and led to the enhancement of state-based programs to make states better able to prevent, detect, and respond to the threat of WNV and other vector-borne infectious diseases. The establishment of this national program has also enhanced viral laboratory capacity, veterinarian epidemiology capacity, and surveillance of disease. A reduction of \$16.9 million will decrease the amount of funds available to state and local health departments to respond to the nationwide epidemic while making every attempt to distribute funds according to the profile of the WNV epidemic. Several years of CDC funds have allowed states to develop and enhance their WNV activities, CDC will also limit funding for extramural and intramural research.

**Upgrading State and Local Capacity (-\$125.4 million)**

CDC's funding for upgrade state and local capacity has contributed significantly to strengthening preparedness for a response to bioterrorism, outbreaks of infectious disease, and other public health threats and emergencies. While recognizing competing priorities, CDC proposes a reduction of \$125.4 million to Upgrading State and Local Capacity. During FY 2006, states have received pandemic influenza funding for activities similar to those funded through the Upgrading State and Local Capacity Program. CDC will focus funding to state and local governments to continue to upgrade capacity.

**Buildings and Facilities (-\$113.6 million)**

The FY 2008 Budget of \$20 million for Buildings and Facilities will be used for repairs and improvements (R & I) of CDC's buildings. CDC will carry over necessary funding in FY 2007 to meet additional R&I needs in FY 2008.

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

The FY 2008 Budget for the Preventive Health and Health Services Block Grant eliminates this program, a decrease of \$99 million below the FY 2007 Continuing Resolution. As CDC strives to improve efficiency and effectiveness, other existing resources will continue to be available for programs which have traditionally addressed similar public health issues.

**BioSense (-\$0.2 million)**

With the funds proposed in FY 2008 for BioSense, CDC will focus on communicable infectious disease threats and preserving BioSense's software development and data analysis capability. In an effort to improve program performance, CDC proposes to realign the effort and narrow the scope of BioSense to public health emergency preparedness. To do so, CDC will limit the number of participating cities and restrict program expansion to include only the most populous U.S. cities and improve the system's surveillance for seasonal influenza and conduct exercises with this system related to a bioterrorism event.

**Public Health Information Network (-\$0.4 million)**

The FY 2008 President's Budget will reduce contract services for Public Health Information Network-related activities. CDC anticipates savings in future years as the Agency continues to gain efficiencies through the consolidation of interoperable systems and through more efficient IT processes. By standardizing systems and using common code base for all installations, CDC expects to save on development, installation, and training costs.

**Health Marketing Internal Support (-\$0.5 million)**

With a decrease of \$0.5 million in FY 2008, CDC will reduce support for embedded staff in the National Centers who perform marketing and communications functions; public health system funding to core partners; and consulting services for broadcast engineering. These reductions will be made through expected efficiencies as the functions of CDC's health marketing program continue to be enhanced.

**Anthrax (-\$13.9 million)**

In FY 2008, CDC proposes to eliminate funding for the anthrax research study. CDC has completed the anthrax vaccine clinical trial interim safety analysis, presented the results to key stakeholders, and submitted the final report detailing findings to the Food and Drug Administration. The information gained over the course of the study will not be compromised due to the cessation in funding.

**Vaccines for Children (-\$143.3 million)**

The FY 2008 Budget includes a decrease of \$143.3 million in the VFC program. This reduction reflects a reduction for pediatric influenza stockpile funding, reduced needs to support CDC's Vaccine Management Business Improvement Plan (VMBIP) that are no longer necessary in FY 2008, and reduced projected needs for vaccine purchase due to a decline in catch-up funding for some vaccines. Funding for VFC has increased by more than \$780 million since FY 2006.

**Bulk Monovalent Influenza Vaccine (-\$29.7 million from the FY 2006 appropriation)**

The FY 2006 appropriation for CDC included no-year funding for CDC to purchase bulk monovalent influenza vaccine, which would allow for unfinished vaccine to be set aside to package, fill, and label for distribution to the population in the event of a vaccine shortage. Given in increase in production capacity, the FY 2006 funding is not needed for this purpose. The FY 2008 request includes the rescission of these funds from CDC's FY 2006 Budget.

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# **BUDGET EXHIBITS**

## APPROPRIATION LANGUAGE AND ANALYSIS

### **DISEASE CONTROL, RESEARCH, AND TRAINING**

*To carry out titles II, III, VII, XI, XV, XVII, XIX, XXI, and XXVI of the Public Health Service Act, sections 101, 102, 103, 201, 202, 203, 301, and 501 of the Federal Mine Safety and Health Act of 1977, sections 20, 21, and 22 of the Occupational Safety and Health Act of 1970, title IV of the Immigration and Nationality Act, section 501 of the Refugee Education Assistance Act of 1980, and for expenses necessary to support activities related to countering potential biological, disease, nuclear, radiological, and chemical threats to civilian populations; including purchase and insurance of official motor vehicles in foreign countries; and purchase, hire, maintenance, and operation of aircraft, \$5,716,651,000 of which \$20,000,000 shall remain available until expended for equipment, construction, and renovation of facilities; of which \$581,335,000 shall remain available until expended for the Strategic National Stockpile of which \$121,223,000 for international HIV/AIDS shall remain available until September 30, 2009 and of which \$30,000,000 shall remain available until expended for section 2625 of the PHS Act. 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) \$109,921,000 to carry out the National Center for Health Statistics surveys; (3) \$24,751,000 to carry out information systems standards development and architecture and applications-based research used at local public health levels; (4) \$463,000 for Health Marketing evaluations; (5) \$31,000,000 to carry out Public Health Research; and (6) \$87,071,000 to carry out research activities within the National Occupational Research Agenda: Provided further, That none of the funds made available for injury prevention and control at the Centers for Disease Control and Prevention may be used, in whole or in part, to advocate or promote gun control: Provided further, That up to \$31,800,000 shall be made available until expended for Individual Learning Accounts for full-time equivalent employees of the Centers for Disease Control and Prevention: Provided further, That the Director may redirect the total amount made available under authority of Public Law 101–502, section 3, dated November 3, 1990, to activities the Director may so designate: Provided further, That the Congress is to be notified promptly of any such transfer: Provided further, That not to exceed \$12,500,000 may be available for making grants under section 1509 of the Public Health Service Act to not more than 15 States, tribes, or tribal organizations: Provided further, That 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.*

## **CENTERS FOR DISEASE CONTROL AND PREVENTION LANGUAGE ANALYSIS**

### ***LANGUAGE ANALYSIS***

<b>PURCHASE AND LANGUAGE PROVISION</b>	<b>EXPLANATION</b>
“...including purchase and insurance of official motor vehicles in foreign countries...”	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.
“...and purchase, hire, maintenance, and operation of aircraft...”	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.
“...of which \$20,000,000 shall remain available until expended for equipment, construction, and renovation of facilities ...”	Provides specific authorization for CDC to fund the construction, maintenance, and improvement of CDC buildings and facilities, which requires funding to be available over multiple years.
“...of which \$30,000,000 shall remain available until expended for section 2625 of the PHS act.”	Provides specific authorization for CDC to fund HIV/AIDS testing in states with laws or regulations for voluntary opt-out testing of clients at sexually transmitted disease clinics and substance abuse centers, as authorized in the Ryan White Care Act.
“...such sums as may be derived from authorized user fees, which shall be credited to this account.”	Provides specific authorization to allow all funds collected as user fees to be deposited to this appropriation.

**COMPARISON OF PROPOSED FY 2008 APPROPRIATION LANGUAGE TO FY 2006 ENACTED APPROPRIATION LANGUAGE**

To carry out titles II, III, VII, XI, XV, XVII, XIX, XXI, and XXVI of the Public Health Service Act, sections 101, 102, 103, 201, 202, 203, 301, and 501 of the Federal Mine Safety and Health Act of 1977, sections 20, 21, and 22 of the Occupational Safety and Health Act of 1970, title IV of the Immigration and Nationality Act, section 501 of the Refugee Education Assistance Act of 1980, and for expenses necessary to support activities related to countering potential biological, disease, nuclear, radiological, and chemical threats to civilian populations; including purchase and insurance of official motor vehicles in foreign countries; and purchase, hire, maintenance, and operation of aircraft, ~~\$5,884,934,000, \$5,716,651,000~~ of which ~~\$160,000,000~~ **\$20,000,000** shall remain available until expended for equipment, construction and renovation of facilities; ~~of which \$30,000,000 of the amounts available for immunization activities shall remain available until expended;~~ of which ~~\$530,000,000~~ **\$581,335,000** shall remain available until expended for the Strategic National Stockpile; and of which ~~\$123,883,000~~ **\$121,223,000** for international HIV/AIDS shall remain available until September 30, ~~2007~~.~~2009~~; and of which **\$30,000,000** shall remain available until expended for section 2625 of the PHS act<sup>1</sup>. 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~~ **\$109,921,000** to carry out the National Center for Health Statistics surveys; (3) \$24,751,000 to carry out information systems standards development and architecture and applications-based research used at local public health levels; (4) \$463,000 for Health Marketing evaluations; (5) \$31,000,000 to carry out Public Health Research; and (6) \$87,071,000 to carry out research activities within the National Occupational Research Agenda: Provided further, That none of the funds made available for injury prevention and control at the Centers for Disease Control and Prevention may be used, in whole or in part, to advocate or promote gun control: Provided further, That up to \$31,800,000 shall be made available until expended for Individual Learning Accounts for full-time equivalent employees of the Centers for Disease Control and Prevention: Provided further, That the Director may redirect the total amount made available under authority of Public Law 101-502, section 3, dated November 3, 1990, to activities the Director may so designate: Provided further, That the Congress is to be notified promptly of any such transfer: Provided further, That not to exceed \$12,500,000 may be available for making grants under section 1509 of the Public Health Service Act to not more than 15 States, tribes, or tribal organizations: ~~Provided further, That notwithstanding any other provision of law, a single contract or related contracts for development and construction of facilities may be employed which collectively include the full scope of~~

the project: Provided further, That the solicitation and contract shall contain the clause 'availability of funds' found at 48 CFR 52.232-18: Provided further, That of the funds appropriated, \$10,000 is for official reception and representation expenses when specifically approved by the Director of the Centers for Disease Control and Prevention: ~~Provided further, That employees of the Centers for Disease Control and Prevention or the Public Health Service, both civilian and Commissioned Officers, detailed to States, municipalities, or other organizations under authority of section 214 of the Public Health Service Act, shall be treated as non-Federal employees for reporting purposes only and shall not be included within any personnel ceiling applicable to the Agency, Service, or the Department of Health and Human Services during the period of detail or assignment~~

<sup>1</sup> This language provides no-year funding to CDC's FY 2008 HIV budget for the purpose of HIV/AIDS testing in states with laws or regulations for voluntary opt-out testing of clients at sexually transmitted disease clinics and substance abuse centers.

**HEALTH AND HUMAN SERVICES GENERAL PROVISIONS SECTION LANGUAGE**

*Sec. 216. Funds which are available for Individual Learning Accounts for employees of the Centers for Disease Control and Preventions and the Agency for Toxic Substances and Disease Registry 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 either by CDC or ATSDR.*

*Sec. 217. In addition to any other amounts available for such travel, and notwithstanding any other provision of law, amounts available from this or any other appropriation for the purchase, hire, maintenance, or operation of aircraft by the Centers for Disease Control and Prevention shall be available for travel by the Secretary of Health and Human Services, the Director of the Centers for Disease Control and Prevention, and employees of the Department of Health and Human Services accompanying the Secretary or the Director during such travel.*

*Sec. 219. Of the unobligated balances available under the heading, "Centers for Disease Control and Prevention," in Public Law 109-149, \$29,680,000 are cancelled.*

*Sec. 220. the Director of the Centers for Disease Control and Prevention may reallocate up to one percent of any discretionary funds appropriated for the current fiscal year for the Centers for Disease Control and Prevention between the agency's programs, projects, and activities: Provided, That the transfer should not decrease any program, project, or activity by more than three percent: Provided further, That the reallocation authority granted by this section shall be available only to meet CDC's public health mission: Provided further, That the appropriations committees of both Houses of Congress are notified within 15 days of any reallocation.*

## HEALTH AND HUMAN SERVICES GENERAL PROVISIONS SECTION LANGUAGE ANALYSIS

PURCHASE AND LANGUAGE PROVISION	EXPLANATION
<p><i>Section 216: Funds which are for Individual Learning Accounts for employees of the Centers for Disease control and Prevention and the Agency for Toxic Substances and Disease Registry may be transferred into "Disease Control, Research, and Training" appropriation, to be available only for Individual Learning Accounts: Provided, That the total available for such accounts under the heading "Disease Control, Research, and Training" or "Toxic Substances and Environmental Public Health" for any individual full time equivalent employee may be used while such employee is employed by either agency: Provided further, that such transferred funds shall remain available until expended.</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 Agency for Toxic Substances and Disease Registry.</p>
<p><i>Sec. 217. In addition to any other amounts available for such travel, and notwithstanding any other provision of law, amounts available from this or any other appropriation for the purchase, hire, maintenance, or operation of aircraft by the Centers for Disease Control and Prevention shall be available for travel by the Secretary of Health and Human Services, the Director of the Centers for Disease Control and Prevention, and employees of the Department of Health and Human Services accompanying the Secretary or the Director during such travel.</i></p>	<p>CDC must maintain the ability to purchase or hire aircraft for deployment of the Strategic National Stockpile; testing of new insecticides and formulations; applying the insecticides when outbreaks of mosquito-borne disease, such as encephalitis, occur in populous areas; and any other emergency response operations.</p>
<p><i>Sec. 219. Of the unobligated balances available under the heading, "Centers for Disease Control and Prevention," in Public Law 109-149, \$29,680,000 are cancelled.</i></p>	<p>The FY 2008 estimate rescinds funding provided in FY 2006 for the Bulk Monovalent Influenza Vaccine Stockpile.</p>
<p><i>Sec. 220. the Director of the Centers for Disease Control and Prevention may reallocate up to one percent of any discretionary funds appropriated for the current fiscal year for the Centers for Disease Control and Prevention between the agency's programs, projects, and activities: Provided, That the transfer should not decrease any program, project, or activity by more than three percent: Provided further, That the reallocation authority granted by this section shall be available only to meet CDC's public health mission: Provided further, That the appropriations committees of both Houses of Congress are notified within 15 days of any reallocation.</i></p>	<p>In order to meet CDC's public health mission and achieve the greatest public health impact, the Director of CDC is provided the authority to reallocate up to one percent of discretionary funds between program areas. This will allow for the maximum utilization of funding to ensure urgent threats to public health as well as urgent realities requiring augmented attention are funded appropriately within a given year. CDC requires the ability to maintain an appropriate level of flexibility to ensure health impact can be made across all CDC programs.</p>

**COMPARISON OF PROPOSED FY 2008 HHS GENERAL PROVISIONS LANGUAGE TO**

**FY 2006 HHS GENERAL PROVISIONS LANGUAGE**

Sec. 218. Funds which are available for Individual Learning Accounts for employees of the Centers for Disease Control and Prevention and the Agency for Toxic Substances and Disease Registry 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 either by CDC or ATSDR.

~~Sec. 221. (a) The Headquarters and Emergency Operations Center Building (Building 21) at the Centers for Disease Control and Prevention is hereby renamed as the Arlen Specter Headquarters and Emergency Operations Center.~~

~~(b) The Global Communications Center Building (Building 19) at the Centers for Disease Control and Prevention is hereby renamed as the Thomas R. Harkin Global Communications Center.~~

Sec. 227. In addition to any other amounts available for such travel, and notwithstanding any other provision of law, amounts available from this or any other appropriation for the purchase, hire, maintenance, or operation of aircraft by the Centers for Disease Control and Prevention shall be available for travel by the Secretary of Health and Human Services, the Director of the Centers for Disease Control and Prevention, and employees of the Department of Health and Human Services accompanying the Secretary or the Director during such travel.

**Sec. 219. Of the unobligated balances available under the heading, "Centers for Disease Control and Prevention," in Public Law 109-149, \$29,680,000 are cancelled.<sup>1</sup>**

**Sec. 220. The Director of the Centers for Disease Control and Prevention may reallocate up to one percent of any discretionary funds appropriated for the current fiscal year for the Centers for Disease Control and Prevention between the agency's programs, projects, and activities: Provided, That the transfer should not decrease any program, project, or activity by more than three percent: Provided further, That the reallocation authority granted by this section shall be available only to meet CDC's public health mission: Provided further, That the appropriations committees of both Houses of Congress are notified within 15 days of any reallocation.<sup>2</sup>**

<sup>1</sup> The FY 2008 estimate rescinds funding provided in FY 2006 for the Bulk Monovalent Influenza Vaccine Stockpile.

<sup>2</sup> In order to meet CDC's public health mission and achieve the greatest public health impact, the Director of CDC is provided the authority to reallocate up to one percent of discretionary funds between program areas. This will allow for the maximum utilization of funding to ensure urgent threats to public health as well as urgent realities requiring augmented attention are funded appropriately within a given year. CDC requires the ability to maintain an appropriate level of flexibility to ensure health impact can be made across all CDC programs.

**AMOUNTS AVAILABLE FOR OBLIGATION**

<b>FY 2008 BUDGET SUBMISSION</b> <b>CENTERS FOR DISEASE CONTROL AND PREVENTION</b> <b>DISEASE, CONTROL, RESEARCH AND TRAINING</b> <b>AMOUNTS AVAILABLE FOR OBLIGATION <sup>1</sup></b> <b>(DOLLARS IN THOUSANDS)</b>			
	<b>FY 2006</b> <b>Actual</b>	<b>FY 2007</b> <b>CR</b>	<b>FY 2008</b> <b>Budget</b>
<b>Appropriation:</b>			
Annual	5,978,000,000	5,736,872,000	5,716,651,000
Rescission	(58,848,000)	-	-
Unobligated balance permanently reduced - Bulk Monovalent	-	-	(29,680,000)
<b>Subtotal, adjusted Appropriation</b>	<b>5,919,152,000</b>	<b>5,736,872,000</b>	<b>5,686,971,000</b>
Transfers to Other Accounts (Section 202 Transfer to CMS)	(4,002,000)	-	-
Transfers from Other Accounts (Office of the Secretary)	-	-	-
Transfers from Other Accounts (Department of State)	-	-	-
<b>Subtotal, adjusted Budget Authority</b>	<b>5,915,150,000</b>	<b>5,736,872,000</b>	<b>5,686,971,000</b>
Receipts from CRADA	1,000,000	1,000,000	1,000,000
Recovery of prior year Obligations	3,000,000	-	-
Unobligated balance start of year	300,000,000	(466,000,000)	(477,000,000)
Unobligated balance expiring	(4,000,000)	-	-
Unobligated balance end of year	466,000,000	477,000,000	461,000,000
<b>Total obligations</b>	<b>6,681,150,000</b>	<b>5,748,872,000</b>	<b>5,671,971,000</b>

<sup>1</sup> Excludes the following amounts for reimbursements: FY 2006 \$505,933,000; FY 2007 \$521,111,000; and FY 2008 \$536,744,000.

## SUMMARY OF CHANGES

<b>FY 2008 BUDGET SUBMISSION</b> <b>CENTERS FOR DISEASE CONTROL AND PREVENTION</b> <b>SUMMARY OF CHANGES</b> <b>(DOLLARS IN THOUSANDS )</b>				
	Dollars		FTEs	
<b>FY 2008 Budget (Budget Authority)</b>	<b>\$5,716,651</b>		<b>9,295</b>	
<b>FY 2007 CR (Budget Authority)</b>	<b>\$5,736,874</b>		<b>8,823</b>	
<b>Net Change</b>	<b>(\$20,223)</b>		<b>472</b>	
	FY 2007 CR		Change from Base	
	FTE	Budget Authority	FTE	Budget Authority
<b>Increases:</b>				
1. Pandemic Influenza	---	---	---	\$158,245
2. HIV/AIDS Testing	---	---	---	\$93,000
3. Strategic National Stockpile	---	\$491,390	---	\$89,945
4. Adolescent Health Promotion Initiative	---	---	---	\$17,300
5. Improving Special Pathogens Laboratory Capacity	---	---	---	\$5,192
6. Pay raise	---	---	---	\$3,272
<b>Total Increases</b>	<b>N/A</b>	<b>N/A</b>	<b>0</b>	<b>\$ 366,954</b>
<b>Decreases:</b>				
1. Upgrading State and Local Capacity	---	\$823,674	---	(\$125,407)
2. BioSense	---	\$57,245	---	(\$200)
3. Buildings and Facilities	---	\$133,638	---	(\$ 113,638)
4. Preventive Health & Health Services Block Grant	---	\$99,000	---	(\$99,000)
5. Steps to a Healthier U.S.	---	\$43,641	---	(\$17,255)
6. West Nile virus	---	\$37,008	---	(\$16,900)
7. Anthrax	---	\$13,860	---	(\$13,860)
8. Health Marketing Internal Support	---	\$39,210	---	(\$500)
9. Public Health Information Network (PHIN)	---	\$4,833	---	(\$415)
10. Adjustment (increment)	---	---	---	(\$2)
<b>Total Decreases</b>	<b>N/A</b>	<b>N/A</b>	<b>0</b>	<b>(\$ 387,177)</b>
<b>Built-In:</b>				
1. January 2008 Pay Raise/Locality Pay	---	---	---	18,508
2. Annualization of FY 2007 Pay Increase	---	---	---	4,648
3. Two days Extra Pay	---	---	---	6,279
4. Within-Grade Increases	---	---	---	14,807
5. Rental Payments to GSA and Others	---	---	---	1,425
6. HHS Service & Supply Fund	---	---	---	0
7. Vaccine Price Increase	---	---	---	21,949
8. Inflation Costs on Other Objects	---	---	---	32,081
<b>Total Built-In</b>	<b>8,493</b>	<b>\$5,736,874</b>	<b>472</b>	<b>99,697</b>
1. Absorption of Current Services	---	---	---	(\$99,697)
<b>Total</b>	<b>---</b>	<b>---</b>	<b>---</b>	<b>(\$99,697)</b>
<b>Total Increases (Budget Authority)</b>	<b>8,493</b>	<b>\$5,736,874</b>	<b>472</b>	<b>\$466,651</b>
<b>Total Decreases (Budget Authority)</b>	<b>N/A</b>	<b>N/A</b>	<b>0</b>	<b>(\$486,874)</b>
<b>NET CHANGE - L/HHS/ED BUDGET AUTHORITY</b>	<b>8,493</b>	<b>\$5,736,874</b>	<b>472</b>	<b>(\$20,223)</b>
<b>Program Level Changes</b>				
1. Vaccines for Children	---	\$2,905,330	---	(\$143,373)
2. ATSDR	330	\$74,905	---	\$99
3. PHS Evaluation Transfers	---	265,100	---	\$900
4. User Fees	---	\$2,226	---	\$0
<b>Total - Program Level Net Increase</b>	<b>330</b>	<b>\$3,247,561</b>	<b>0</b>	<b>(\$142,374)</b>
<b>NET CHANGE: BUDGET AUTHORITY &amp; PROGRAM LEVEL</b>	<b>8,823</b>	<b>\$8,984,435</b>	<b>472</b>	<b>(\$162,597)</b>

**FY 2008 CONGRESSIONAL JUSTIFICATION**  
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EXHIBITS  
BUDGET AUTHORITY BY ACTIVITY (ALL PURPOSE TABLE)

**BUDGET AUTHORITY BY ACTIVITY (ALL PURPOSE TABLE)**

<b>FY 2008 BUDGET SUBMISSION CENTERS FOR DISEASE CONTROL AND PREVENTION ALL PURPOSE TABLE (DOLLARS IN THOUSANDS)</b>					
Budget Activity	FY 2006 Actual	FY 2007 President's Budget	FY 2007 CR	FY 2008 Budget	FY 2008 +/- FY 2007
<b>Infectious Diseases<sup>1,2</sup></b>					
Budget Authority	\$1,682,362	\$1,675,990	\$1,645,832	\$1,781,574	\$135,742
PHS Evaluation Transfers	\$12,794	\$12,794	\$12,794	\$12,794	\$0
<b>Subtotal, Infectious Diseases -</b>	<b>\$1,695,156</b>	<b>\$1,688,784</b>	<b>\$1,658,626</b>	<b>\$1,794,368</b>	<b>\$135,742</b>
<b>Health Promotion</b>	\$958,025	\$929,208	\$958,687	\$958,732	\$45
<b>Health Information and Service</b>					
Budget Authority	\$84,670	\$124,339	\$84,731	\$108,361	\$23,630
PHS Evaluation Transfers	\$134,235	\$134,235	\$134,235	\$135,135	\$900
<b>Subtotal, Health Information and Service -</b>	<b>\$218,905</b>	<b>\$258,574</b>	<b>\$218,966</b>	<b>\$243,496</b>	<b>\$24,530</b>
<b>Environmental Health and Injury Prevention</b>	\$287,474	\$279,309	\$287,674	\$287,674	\$0
<b>Occupational Safety and Health</b>					
Budget Authority	\$175,812	\$163,123	\$165,928	\$165,927	(\$1)
PHS Evaluation Transfers	\$87,071	\$87,071	\$87,071	\$87,071	\$0
<b>Subtotal, Occupational Safety and Health -</b>	<b>\$262,883</b>	<b>\$250,194</b>	<b>\$252,999</b>	<b>\$252,998</b>	<b>(\$1)</b>
<b>Global Health<sup>3</sup></b>					
Budget Authority	\$311,624	\$381,103	\$310,420	\$379,719	\$69,299
Department of Defense Appropriation	\$68,000	\$0	\$0	\$0	\$0
<b>Subtotal, Global Health -</b>	<b>\$379,624</b>	<b>\$381,103</b>	<b>\$310,420</b>	<b>\$379,719</b>	<b>\$69,299</b>
<b>Public Health Research (PHS Evaluation Transfers)</b>	\$31,000	\$31,000	\$31,000	\$31,000	\$0
<b>Public Health Improvement and Leadership (PHIL)</b>					
Budget Authority	\$189,106	\$190,165	\$189,236	\$190,412	\$1,176
Department of Defense Appropriation	\$75,000	\$0	\$0	\$0	\$0
<b>Subtotal, PHIL -</b>	<b>\$264,106</b>	<b>\$190,165</b>	<b>\$189,236</b>	<b>\$190,412</b>	<b>\$1,176</b>
<b>Preventive Health &amp; Health Services Block Grant (PHHSBG)</b>	\$98,932	\$0	\$99,000	\$0	(\$99,000)
<b>Buildings and Facilities</b>	\$158,291	\$29,700	\$133,638	\$20,000	(\$113,638)
<b>Business Services Support<sup>4</sup></b>	\$317,576	\$303,815	\$317,781	\$319,877	\$2,096
<b>Terrorism</b>					
Budget Authority	\$1,576,173	\$1,606,414	\$1,543,947	\$1,504,375	(\$39,572)
Department of Defense Appropriation	\$55,000	\$0	\$0	\$0	\$0
<b>Subtotal, Terrorism -</b>	<b>\$1,631,173</b>	<b>\$1,606,414</b>	<b>\$1,543,947</b>	<b>\$1,504,375</b>	<b>(\$39,572)</b>
CDC-wide HIV/AIDS (non-add) -	\$838,225	\$929,483	\$837,384	\$930,383	\$92,999
<b>FY 2006 Pandemic Influenza One-time Funding - Department of Defense<sup>5</sup></b>	\$77,000	\$0	\$0	\$0	\$0
<b>FY 2006 Pandemic Influenza Second Supplemental</b>	\$200,000	\$0	\$0	\$0	\$0
<b>Total, L/HHS/ED<sup>1,5</sup> -</b>	<b>\$6,315,045</b>	<b>\$5,683,166</b>	<b>\$5,736,874</b>	<b>\$5,716,651</b>	<b>(\$20,223)</b>
<b>Total, L/HHS/ED (inc. PHS and supplementals)<sup>1,5</sup>-</b>	<b>\$6,580,145</b>	<b>\$5,948,266</b>	<b>\$6,001,974</b>	<b>\$5,982,651</b>	<b>(\$19,323)</b>
PHS Evaluation Transfer (non-add)	\$265,100	\$265,100	\$265,100	\$266,000	\$900
Department of Defense Appropriation (non-add)	\$275,000	\$0	\$0	\$0	\$0
Agency for Toxic Substances and Disease Registry <sup>6</sup>	\$74,905	\$75,004	\$74,905	\$75,004	\$99
Vaccines for Children <sup>1</sup>	\$1,974,295	\$2,388,100	\$2,905,330	\$2,761,957	(\$143,373)
User Fees	\$2,226	\$2,226	\$2,226	\$2,226	\$0
<b>Total, CDC/ATSDR Program Level<sup>1,5</sup> -</b>	<b>\$8,631,571</b>	<b>\$8,413,596</b>	<b>\$8,984,435</b>	<b>\$8,821,838</b>	<b>(\$162,597)</b>
<b>Bulk Monovalent Stockpile Rescission<sup>7</sup></b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>(\$29,680)</b>	<b>(\$29,680)</b>
<b>Full-Time Equivalents (FTEs)<sup>8</sup> -</b>	<b>8,510</b>	<b>9,041</b>	<b>8,823</b>	<b>9,295</b>	<b>472</b>

<sup>1</sup> The 2007 CR and 2008 Budget do not continue the proposed law change to the Immunization programs from the FY 2007 President's Budget.

<sup>2</sup> This reflects the new CCID reorganizational structure.

<sup>3</sup> Funding does not include transfers to CDC from the Department of State Office of the Global AIDS Coordinator (\$607.9 million in FY 2006), as part of the President's Emergency Plan for AIDS Relief.

<sup>4</sup> Funding in FY 2006 and 2007 CR for Business Services Support includes a comparability adjustment of -\$0.039 million for activities that were jointly funded in prior years, and are financed centrally in the General Departmental Management account in the FY 2008 request.

<sup>5</sup> FY 2006 funding includes \$77 million in one-time costs related to pandemic influenza planning not carried forward into FY 2007 and 2008.

<sup>6</sup> FY 2006 funding for ATSDR includes a rescission of 0.476% for Interior, Environment, and Related Agencies.

<sup>7</sup> The 2008 Budget reflects a rescission from FY 2006 of \$29.7 million related to Bulk Monovalent Influenza Vaccine.

<sup>8</sup>The FY 2007 and 2008 FTE's have been revised to reflect an increase need in annual FTE usage.

**BUDGET AUTHORITY BY OBJECT**

<b>FY 2008 BUDGET SUBMISSION</b> <b>CENTERS FOR DISEASE CONTROL AND PREVENTION</b> <b>OBJECT CLASSIFICATION DIRECT OBLIGATIONS</b> <b>(DOLLARS IN THOUSANDS)</b>			
	<b>FY 2007 CR</b>	<b>FY 2008 Budget</b>	<b>FY 2008 +/- FY 2007</b>
<b>Personnel Compensation:</b>			
Full-Time Permanent (11.1)	488,434	514,832	26,398
Other than Full-Time Permanent (11.3)	54,778	57,738	2,960
Other Personnel Comp. (11.5)	23,186	24,439	1,253
Military Personnel (11.7)	58,958	62,219	3,261
Special Personal Service Comp. (11.8)	1,271	1,342	71
<b>Total Personnel Compensation</b>	<b>626,627</b>	<b>660,570</b>	<b>33,943</b>
Civilian personnel Benefits (12.1)	151,562	159,753	8,191
Military Personnel Benefits (12.2)	38,131	40,240	2,109
Benefits to Former Personnel (13.0)	0	0	0
<b>SubTotal Pay Costs</b>	<b>816,320</b>	<b>860,563</b>	<b>44,243</b>
Travel (21.0)	42,072	41,004	(1,068)
Transportation of Things (22.0)	20,667	20,143	(524)
Rental Payments to GSA (23.1)	67,838	66,117	(1,721)
Rental Payments to Others (23.2)	1,011	985	(26)
Communications, Utilities, and Misc. Charges (23.3)	21,229	20,690	(539)
Printing and Reproduction (24.0)	8,974	8,746	(228)
<b>Other Contractual Services:</b>			
Advisory and Assistance Services (25.1)	375,710	366,176	(9,534)
Other Services (25.2)	211,886	206,509	(5,377)
Purchases from Government Accounts (25.3)	342,281	333,595	(8,686)
Operation and Maintenance of Facilities (25.4)	76,418	74,479	(1,939)
Research and Development Contracts (25.5)	124,309	123,645	(664)
Medical Services (25.6)	18,549	18,078	(471)
Operation and Maintenance of Equipment (25.7)	20,806	20,278	(528)
Subsistence and Support of Persons (25.8)	3,451	3,363	(88)
<b>Subtotal Other Contractual Services</b>	<b>1,173,410</b>	<b>1,146,123</b>	<b>(27,287)</b>
Supplies and Materials (26.0)	522,591	509,330	(13,261)
Equipment (31.0)	69,310	67,551	(1,759)
Land and Structures (32.0)	101,807	99,224	(2,583)
Investments and Loans (33.0)	0	0	0
Grants, Subsidies, and Contributions (41.0)	2,890,951	2,875,499	(15,452)
Insurance Claims and Indemnities (42.0)	101	98	(3)
Interest and Dividends (43.0)	593	578	(15)
Refunds (44.0)	0	0	0
<b>Subtotal Non-Pay Costs</b>	<b>4,920,554</b>	<b>4,856,088</b>	<b>(64,466)</b>
<b>Total Budget Authority</b>	<b>5,736,874</b>	<b>5,716,651</b>	<b>(20,223)</b>

**SALARIES AND EXPENSES**

<b>FY 2008 BUDGET SUBMISSION CENTERS FOR DISEASE CONTROL AND PREVENTION SALARIES AND EXPENSES (DOLLARS IN THOUSANDS)</b>			
	<b>FY 2007 CR</b>	<b>FY 2008 Budget</b>	<b>FY 2008 +/- FY 2007</b>
<b>Personnel Compensation:</b>			
Full-Time Permanent(11.1)	488,434	514,832	26,398
Other than Full-Time Permanent (11.3)	54,778	57,738	2,960
Other Personnel Comp. (11.5)	23,186	24,439	1,253
Military Personnel (11.7)	58,958	62,219	3,261
Special Personal Service Comp. (11.8)	1,271	1,342	71
<b>Total Personnel Compensation</b>	<b>626,627</b>	<b>660,570</b>	<b>33,943</b>
Civilian personnel Benefits (12.1)	151,562	159,753	8,191
Military Personnel Benefits (12.2)	38,131	40,240	2,109
Benefits to Former Personnel (13.0)	0	0	0
<b>SubTotal Pay Costs</b>	<b>816,320</b>	<b>860,563</b>	<b>44,243</b>
Travel (21.0)	42,072	41,004	(1,068)
Transportation of Things (22.0)	20,667	20,143	(524)
Rental Payments to Others (23.2)	1,011	985	(26)
Communications, Utilities, and Misc. Charges (23.3)	21,229	20,690	(539)
Printing and Reproduction (24.0)	8,974	8,746	(228)
<b>Other Contractual Services:</b>			
Advisory and Assistance Services (25.1)	43,108	42,014	(1,094)
Other Services (25.2)	82,319	80,230	(2,089)
Purchases from Government Accounts (25.3)	10,391	10,128	(263)
Operation and Maintenance of Facilities (25.4)	32,744	31,913	(831)
Medical Services (25.6)	18,549	18,078	(471)
Operation and Maintenance of Equipment (25.7)	12,260	11,949	(311)
Subsistence and Support of Persons (25.8)	3,451	3,363	(88)
<b>Subtotal Other Contractual Services</b>	<b>202,822</b>	<b>197,675</b>	<b>(5,147)</b>
Supplies and Materials (26.0)	112,852	109,988	(2,864)
<b>Subtotal Non-Pay Costs</b>	<b>409,627</b>	<b>399,231</b>	<b>(10,396)</b>
<b>Total Budget Authority</b>	<b>1,225,947</b>	<b>1,259,794</b>	<b>33,847</b>

**SIGNIFICANT ITEMS IN APPROPRIATIONS REPORTS HOUSE**

**SIGNIFICANT ITEMS FOR INCLUSION IN  
THE FY 2008 CONGRESSIONAL JUSTIFICATION  
AND OPENING STATEMENTS  
HOUSE REPORT NO. 109-515**

**CENTERS FOR DISEASE CONTROL AND PREVENTION**

Item

**Hepatitis** – . . . . The Committee is concerned that more than 75 percent of the 4,000,000 people with hepatitis C are unaware of their condition and urges CDC to support a campaign of public announcements that will highlight the need for appropriate screening and medical follow up for target populations. The Committee also encourages the Division of Viral Hepatitis to collaborate with the Health Resources and Services Administration (HRSA) to implement improved HCV screening programs for HIV-infected individuals served by HRSA programs. (Page 62)

Action taken or to be taken

Awareness of infection status has increased significantly from the 1990s, when only 25% of hepatitis C virus (HCV)-infected persons had knowledge of their infection. However, approximately half of HCV-positive individuals remain unaware of their infection status and, therefore, of their potential risk for serious liver disease or liver cancer. During FY 2006, CDC funded seven organizations to develop, evaluate, and distribute educational materials on viral hepatitis for health professionals, patients, and the public. These and other informational materials are also available online, and in 2006, approximately 600,000 persons used the Internet to access this information about viral hepatitis. CDC works with the National Viral Hepatitis Roundtable, whose member organizations have developed educational materials and campaigns to increase knowledge and awareness of hepatitis. To improve collaboration with the Health Resources and Services Administration (CDC/HRSA), the CDC/HRSA Advisory Committee on HIV and STD Prevention and Treatment has offered to advise both agencies regarding collaborative efforts to improve prevention and control of viral hepatitis.

Item

**[Prevention and medical management of hepatitis B]** – The Committee encourages the Division of Viral Hepatitis to develop and implement a plan for prevention and medical management of hepatitis B, including strategies for expanded vaccination, preventive education, surveillance and early detection. (Page 62)

Action taken or to be taken

To expand hepatitis B (HBV) prevention efforts, CDC and the Advisory Committee for Immunization Practices recently updated the national recommendations that guide HBV vaccination for infants, children, adolescents, and adults. The federal support provided to implement routine childhood and adolescent vaccination has resulted in large reductions in the incidence of acute HBV. However, vaccination coverage among adults at risk for HBV infection remains low. In 2005, most of the 50,000 persons newly infected with HBV were adults. In the absence of a national vaccination program for adults, CDC encourages all state and local health agencies to use funds from Section 317 of the Public Health Service Act to increase support for adult HBV vaccination. In FY 2006, CDC issued new guidance to help immunization programs identify and manage persons with chronic HBV, reflecting the value of new treatments for infected persons and the HBV vaccination of their close contacts. In FY 2007, CDC will convene a consultation of experts in viral hepatitis prevention and care to help the agency prepare similar guidance for other health settings. Also in FY 2007, CDC plans to issue a request for proposals to fund viral hepatitis coordinators in all states to improve the delivery of viral hepatitis prevention services in health-care settings and public health programs that serve adults at risk for viral hepatitis. The aim of this effort is to decrease the incidence of new infections of hepatitis A (HAV), HBV and hepatitis C (HCV) (primary prevention) and to decrease risks for chronic liver disease, including cirrhosis and liver cancer, in persons with chronic HBV infection or chronic HCV infection (secondary prevention).

Item

**Community-associated Methicillin-resistant Staphylococcus aureus (CA-MRSA)** – The Committee is concerned about the explosion in virulence and prevalence of MRSA strains in the United States. Compounding this problem is a fundamental shift from primarily hospital-based transmission to community-based transmission of MRSA. The spread of CA-MRSA through perfectly healthy community members with no hospital contact concerns the Committee.

Within the funds provided, the Committee encourages CDC to conduct a strong, extramural research program in MRSA epidemiology and pathophysiology. The Committee encourages CDC to maximize this MRSA research through continued support for entities with established MRSA research programs. (Page 62)

Action taken or to be taken

Since bringing the emergence of community-associated MRSA (CA-MRSA) to the attention of the public health and medical community in a 1999 CDC Morbidity and Mortality Weekly Report (MMWR), CDC has continued to conduct and fund research to gain a better understanding of the epidemiology, microbiology, and prevention strategies of CA-MRSA. While healthcare-associated transmission remains a larger problem, CA-MRSA continues to emerge. After the initial report, CDC collaborated with public health authorities to conduct outbreak investigations of CA-MRSA in various populations to gain an understanding of populations at risk, transmission dynamics, and control measures. Since the time of these seminal studies, CDC has continued to fund and collaborate with health departments, academic institutions, government agencies, and professional organizations to monitor the changing epidemiology and microbiology of CA-MRSA so as to inform prevention and control efforts. In the past six years CDC has provided over \$5 million dollars for extramural research in addition to extensive personnel time and laboratory resources at no cost to external partners. CDC continues to support and collaborate with external partners to address knowledge gaps in both healthcare and community-associated MRSA with the goal of preventing and controlling MRSA infections.

Item

***Infertility Prevention and screening*** – . . . . The Committee is aware that where it has been established, CDC's infertility prevention program has reduced chlamydia rates by 66 percent and decreased treatment costs by over 80 percent. The Committee encourages CDC to expand the infertility screening program. (Page 63)

Action Taken or to be taken

Access to screening and treatment is the primary prevention strategy to reduce prevalence of chlamydia and gonorrhea infections and resulting infertility. Annual chlamydia screening for sexually-active women under age 26 is recommended by CDC and all relevant professional agencies and organizations and by numerous other countries. Since its inception in 1993, the National Infertility Prevention Program has expanded to all 50 states, and programs have made great strides in expanding chlamydia screening and treatment to young women in public sector settings. Screening coverage in the public sector is estimated at approximately 60 percent. CDC continues to support screening in the public sector through this important program.

However, more than 50 percent of chlamydia cases are reported from the private sector. Data indicate that screening coverage in the private sector is less than 50 percent in both commercial and Medicaid managed care plans. With existing resources, CDC will continue to support screening in the public sector, explore ways to partner with other organizations to increase screening in the private sector, and explore ways of dealing with the increased drug resistance of gonorrhea. Only one class of drugs is now available to treat this infection, which is an important cause of infertility.

Item

***Nontuberculous Mycobacteria (NTM)*** – Mycobacteria are environmental organisms found in both water and soil that can cause substantial respiratory damage. The Committee is aware of the increasing incidence of NTM pulmonary infections in women, particularly involving rapidly growing mycobacteria, an inherently resistant subspecies. The Committee encourages CDC to work towards a better understanding of NTM and enhancing diagnostics and treatment and promoting education of health care providers. Further, the Committee encourages CDC to dedicate efforts to organize, coordinate and implement an NTM program to evaluate prevalence, risk factors, and comorbidities. (Page 63)

Action taken or to be taken

To address concerns regarding disease caused by nontuberculous mycobacteria (NTM), CDC is convening two expert consultations. These consultations will consist of experts from across CDC, other federal agencies such as the National Institutes of Health (NIH), and non-federal external partners from academic medical institutions and public health agencies. The purpose of these consultations is to develop an action plan for CDC to evaluate prevalence, risk factors, and comorbidities and conduct surveillance for NTM. The mycobacteriology laboratory branch of CDC's Division of Tuberculosis Elimination currently serves as a national reference lab for diagnosis of NTM for local and state public health labs and private medical labs. As a public health agency, CDC is not routinely involved in the treatment of individual patients and has a limited role in conducting clinical trials. CDC maintains close communication with NIH with regard to that Agency's support of clinical trials for NTM, including a grant to the National Jewish Medical Center in Denver, Colorado.

Item

**Sexually transmitted infections** – The Committee is pleased that CDC has funded research aimed at assessing the extent to which medical students and physicians are familiar with and practice screening and counseling tailored to individual patients. Despite widespread condom social marketing for the past twenty years, 40,000 new HIV infections are reported every year and other sexually transmitted infections (STIs) are at unprecedented levels. Significant deficits exist in the current sexual health medical education, and many members of the public at risk for STIs are unaware of their need to be screened. To address these problems the Committee urges CDC to: (1) promote evidence-based medical school curriculum guidelines for sexual health that will promote risk avoidance and non-condom-related risk reduction; and (2) harness the ever-growing power of the Internet to develop innovative and attractive strategies in a manner that promotes risk avoidance and non-condom-related risk reduction that will efficiently educate the public about their STI risks. (Page 63/64)

Action taken or to be taken

CDC has funded the Faculty Expansion Program (FEP) at U.S. medical schools to 1) provide STD training and education by developing faculty positions dedicated to the area of STD clinical care, prevention, and control in medical schools where such clinical or research expertise did not exist; and 2) support the development of linkages between health departments and medical schools in the area of STD prevention through jointly appointed staff who strengthen health department STD programmatic activities by undertaking clinical care, research, and teaching responsibilities. Since its inception in 1996, funding has been provided to two cohorts of four medical schools, for five years each (total of eight medical schools). Such dedicated STD training in medical schools contributes to a workforce that is better able to recognize, treat, and prevent STDs, as well as conduct research in STD prevention and treatment. Funding for this program will end in February of 2007.

For the past 25 years, CDC has funded a network of STD Prevention Training Centers which train medical school faculty, medical students and public health providers in a full range of STD prevention and treatment tools, including risk avoidance and non-condom-related risk reduction such as risk reduction counseling, vaccination, screening and treatment. In addition, CDC is taking advantage of new technologies to reach health care providers and medical students, including regular podcasts and webcasts.

Because the Internet has become an important venue for initiating behaviors that put people at risk for STD/HIV, CDC has been engaged in research on the Internet and STD/HIV prevention since 1998. In addition to providing health promotion information on its own website, CDC also works with Internet service providers and website owners to develop and provide health promotion content and interventions that are integrated into other websites. CDC is creating a compendium of locally-created Internet programs, including outreach and programs to facilitate STD and HIV testing to allow local health departments to search for materials and protocols and adapt them for local use.

CDC has funded the establishment of a Technology Center of Excellence, a group of experts who work in collaboration with CDC scientists to develop, pilot, evaluate, translate and disseminate Internet-based STD prevention programs and interventions.

Item

**Syphilis elimination** – The Committee is aware that progress in controlling syphilis has been substantial as a result of focused efforts in targeted populations. The Committee recognizes the urgency of controlling syphilis because of the impact of this STD on the spread of HIV infection and on infant health. The Committee is concerned that syphilis demonstrates the continuance of racial disparities in health and recommends CDC provide resources to expand the syphilis control program. (Page 64)

Action taken or to be taken

Despite important accomplishments since the 1999 launch of the National Syphilis Elimination Effort, overall syphilis rates have been on the rise since 2001, largely due to increases in syphilis among men who have sex with men (MSM). Overall, the primary and secondary (P&S) syphilis rate among males increased 68 percent from 1999 to 2004. While surveillance data are not available by risk behavior, a separate CDC analysis suggests that approximately 64 percent of all adult P&S syphilis cases in 2004 were among MSM, up from an estimated 5 percent in 1999. In addition, P&S syphilis rates have increased among African Americans in 2004, for the first time in more than a decade, with the increase largely associated with significant increases among black men (up 22.6% from 2003 to 2004).

In 2006, CDC began making adjustments within existing Syphilis Elimination (SE) funding to be more responsive to the changing epidemic. CDC notified High Morbidity Area (HMA) partners that further adjustments would be made in subsequent years, with or without increases in funds. For 2007, CDC revised its funding formula for state and local programs funded with SE funds to reflect the evolving nature of the syphilis epidemic. While CDC recognizes the need to maintain adequate funding levels to support local SE activities, it is also imperative that funds are able to

move to areas where syphilis morbidity requires greater investment. With existing funding, CDC will be able to explore further reallocations of resources between HMAs, while remaining vigilant for evidence of resurgence of syphilis in HMAs where rates have fallen.

Item

**Immunization** – . . . . The Committee recommendation includes \$5,000,000 above the request for the CDC to expand funding for vaccine safety research, particularly with respect to investigator initiated, peer reviewed, extramural research. Furthermore, the Committee urges that this funding be used for non-epidemiology research, to better understand risk factors for serious adverse reactions, to develop screening tools to eliminate from vaccination those children at greater risk for such reactions, and to develop effective treatments and interventions for children suffering severe adverse reactions. (Page 65)

Action taken or to be taken

CDC received \$1.49M in FY 2006 to expand funding for investigator-initiated, peer-reviewed, extramural vaccine safety research.

CDC submitted a statement of work (SOW) to GovWorks, a Federal Acquisition Center under the Department of the Interior, for the solicitation and selection of an independent contractor to develop the Request for Proposals (RFP), coordinate the review and selection process, and manage the implementation of this extramural vaccine safety research activity.

CDC posted a Request for Information (RFI) in Federal Business Opportunities (FedBizOpps.gov) from July 19 through August 17, 2006 to solicit information from the public about the design and implementation of the extramural immunization safety research activity. CDC received a total of ten comments, which were posted on the CDC website ([www.cdc.gov](http://www.cdc.gov)) and will be shared with the independent contractor, as described above, for consideration in the development of the RFP.

The independent contractor solicited through GovWorks will be selected in early calendar year (CY) 2007. The RFP for the extramural vaccine safety research activity will be announced publicly in early CY 2007. It is anticipated that the RFP process will be completed early spring 2007, with the selected research activities) beginning no later than mid-summer 2007.

Any additional funds appropriated in subsequent fiscal years for this activity will be handled in a similar, transparent manner.

Item

**Immunization safety** – The Committee is concerned that CDC has failed to implement the recommendations of the Institute of Medicine (IOM) report: Vaccine Safety Research, Data Access and Public Trust. In fiscal year 2006, this Committee expressed particular interest in seeing CDC move forward with the IOM recommendations that the CDC: (1) establish an independent oversight board to review CDC's vaccine safety research agenda, study protocols, and changes in study protocols, and (2) initiate conversations with managed care organizations involved in the vaccine safety datalink (VSD) to ensure that independent researchers have access to all VSD data, particularly post-2000 data through the National Center for Health Statistics. The Committee expects the CDC to implement these provisions immediately. (Page 66)

Action taken or to be taken

CDC reviewed each of the 28 recommendations made by the Institute of Medicine (IOM) in its 2005 report, Vaccine Safety Research, Data Access, and Public Trust. CDC publicly posted its response to each recommendation on its website in June 2006 and is taking steps to address them.

CDC has consulted with the Department of Health and Human Services' National Vaccine Program Office (NVPO) and its National Vaccine Advisory Committee to (NVAC) to consider options for facilitating broad stakeholder participation in a scientific review of the CDC Vaccine Safety Datalink (VSD) research plan. NVPO and NVAC have agreed to assist CDC with such a review of the VSD research plan in 2007. The review will be facilitated by the NVAC Vaccine Safety Subcommittee, whose mission is to consider policy options and inform NVAC discussions and recommendations regarding vaccine safety issues. The review will be publicly announced in the Federal Register (as required) and be open to the public. The Subcommittee will present the outcome of the meeting to NVAC for consideration and deliberation with the potential to offer further additions or modifications for the Department to consider. Under the NVAC Charter, the NVAC makes recommendations, and provides advice, to the Assistant Secretary for Health (ASH). The ASH will have the option of endorsing, or commenting upon, the NVAC recommendations and forwarding them to CDC. This approach provides CDC a broad, external review process; fosters full public participation; and creates maximal transparency for the process of planning.

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CDC continues to undertake steps toward implementation of the IOM recommendation to establish oversight of research proposals to the VSD Project. Prior to the 2005 IOM recommendation, CDC had already convened panels of external independent experts to advise on and review the research protocol and monitor study progress for two high visibility VSD Project research studies.

CDC has revised Appendix IV of the National Center for Health Statistics (NCHS), Research Data Center (RDC) Data Sharing Guidelines to clearly state that the VSD data available through the Data Sharing Program are final datasets from published studies and VSD data through December 2000 for new vaccine safety studies. These data through December 2000 were submitted to CDC under a contract with the managed care organizations (MCOs) and therefore are accessible to CDC and external researchers who follow RDC procedures. To enhance the privacy protections of their enrollees and the proprietary concerns of the MCOs, the MCOs took control of access to the VSD data after December 2000. Consequently, the data from the VSD Project collected after December 2000 are not available through the Data Sharing Program.

CDC initiated discussions with the MCOs regarding external access to post-2000 VSD data. It was determined that these data can be accessed through a formal collaboration with the MCOs. The external researcher must work through MCO procedures. Any such collaboration is at the discretion of the MCOs, including the continuing collaboration of the MCOs in the VSD Project. CDC does not have the authority to grant access to the VSD data, which is held by MCOs, to external investigators.

Item

**Meningococcal disease** – Meningococcal disease is one of the few diseases that can be fatal or severely debilitating to an otherwise healthy individual within a matter of hours of initial onset. While its early symptoms are easily mistaken for influenza, the consequences of delayed diagnosis and treatment include loss of hearing, limb loss, brain damage and death, yet meningococcal disease is vaccine preventable in most cases. The Committee is aware of the recent improvements in the meningitis vaccine and of CDC's efforts to increase the availability and focus of information on meningococcal disease and ways to prevent it so that the general public will be better educated on the symptoms and prevention methods. The Committee encourages CDC to improve meningococcal education and adolescent immunization programs, including giving consideration to partnering with relevant professional and voluntary health associations to ensure that all families, especially those with adolescents and young adults, are effectively educated on this disease, vaccine availability, and all methods of prevention. (Page 66)

Action taken or to be taken

CDC continues to educate the public and providers about the availability of adolescent vaccines including meningococcal, while also conducting needed research and disseminating findings to promote immunization among adolescents. In 2006, CDC initiated research for an educational campaign related to adolescent immunization through conduct of approximately 36 focus groups with mothers of adolescents in 3 U.S. cities. Interviews of physicians were also conducted. Additional research funded by CDC in 2006 will allow investigators at two U.S. universities to assess the feasibility of delivering new adolescent vaccines in healthcare settings (e.g., teen clinics, emergency departments) that complement traditional primary care settings, where vaccines have traditionally been administered. In follow-up to a 2-day Adolescent Stakeholders meeting sponsored by CDC and the National Vaccine Advisory Committee (NVAC) in June 2005 and attended by over 140 key stakeholders, eight white papers summarizing meeting findings were submitted for final review in 2006 and are expected to be published as a supplement to Pediatrics in 2007.

Information on meningococcal vaccine and adolescent vaccine are included in CDC's annual Epidemiology and Prevention of Vaccine Preventable Diseases Course which is offered through satellite broadcast and held in several sites throughout the year. CDC also conducted a specific broadcast on adult immunization in December 2006 which included meningococcal vaccine. Meningococcal vaccine and adolescent immunization is included in the CDC text Epidemiology and Prevention of Vaccine Preventable Diseases in the 2006 and upcoming 2007 edition. CDC and its partners also produce numerous general immunization educational materials for both public and providers that include information on adolescent vaccines and meningococcal vaccination.

Item

**Chronic obstructive pulmonary disease (COPD)** – COPD is the fourth leading cause of death in the United States and the only one of the top ten causes of death that is on the increase. The Committee urges CDC to expand its data collection efforts on COPD. Specifically, the Committee encourages CDC to include questions in the National Health and Nutrition Examination Survey, the National Health Interview Study and the Behavioral Risk Factor Surveillance Survey that asks about COPD by name. (Page 68)

Action taken or to be taken

The Behavioral Risk Factor Surveillance System (BRFSS) is a unique state-based system that collects data annually on behaviors that place health at risk, on clinical practices, and on access to health care and use of health services. The BRFSS is conducted by State Health Departments in all 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, and Guam, with technical assistance provided by CDC. Each year, the content of the questionnaire is determined by the state BRFSS coordinators, who represent their state health departments, in consultation with CDC based on proposals submitted before the annual BRFSS conference.

In the past, the American Lung Association submitted a proposal for a question to be added to the emerging issues section of the core BRFSS questionnaire. The question would ask respondents if they have ever been told that they have chronic obstructive pulmonary disease (COPD), emphysema, or chronic bronchitis. However, this proposal was among many submitted that addressed important health issues and it was not chosen by the states. Any expansion to the BRFSS system results in additional costs to states and CDC.

Item

**Colorectal cancer** – Colorectal cancer is the third most commonly diagnosed cancer among both men and women in the United States and the second leading cause of cancer-related deaths. When colorectal cancer is detected and treated early, survival is greatly enhanced. The Committee is pleased with the leadership of CDC's national colorectal cancer roundtable in promoting the availability and advisability of screening to both health care providers and the general public. The Committee encourages CDC to continue to expand its partnerships with state health departments, professional and patient organizations, and private industry to combat this devastating disease. (Page 68)

Action taken or to be taken

In FY 2006, CDC awarded \$2.6 million for a colorectal cancer screening demonstration program to increase screening among Americans, aged 50 years or older. Five program sites are participating in this 3-year program. The program sites are the Research Foundation of SUNY at Stony Brook, NY (county-based: Suffolk County), Nebraska Department of Health and Human Services (statewide) Missouri Department of Health and Senior Services(city-based: St. Louis), Maryland Department of Health and Mental Hygiene (city-based: Baltimore), and Seattle and King County, WA(county-based: Seattle and King County). Each site is focusing its screening efforts on low-income men and women who have inadequate or no health insurance coverage for colorectal cancer screening. The program sites provide diagnostic follow-up; conduct public education and outreach; establish standards, systems, policies, and procedures; develop partnerships; collect and track data; and evaluate the effectiveness of the demonstration program.

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 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 maximize resources, improve community-based education and health promotion, share expertise, and effectively reach at-risk populations.

CDC educates Americans about the importance of colorectal cancer screening for men and women aged 50 years or older through its Screen for Life: National Colorectal Cancer Action Campaign. Every state, the District of Columbia and two tribal organizations are campaign partners. Screen for Life also collaborates with the National Colorectal Cancer Research Alliance, a program of the Entertainment Industry Foundation, to promote screening.

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.

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

Item

**Diabetes** – . . . It is estimated that maintaining a certain blood glucose level (A1C target of seven or below) would reduce complications of diabetes and achieve direct medical cost savings of \$35,000,000,000 and indirect cost savings of \$50,000,000,000 over 10 years. The Committee encourages CDC to consider establishing national public-private partnerships to leverage Federal resources with private-sector contributions to expand the National Diabetes

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Education Program and establish a new public awareness campaign to encourage individuals with diabetes to be tested and know their A1C levels so that they can take appropriate action to control their condition. (Page 69)

Action taken or to be taken

CDC, through the National Diabetes Education Program (NDEP), has established a national partnership network involving hundreds of private and public sector organizations. This national partnership network has been a valuable extension of the federally-funded NDEP through their participation on workgroups, testing and marketing of campaign materials, and numerous community-based projects. CDC is always seeking new partners and opportunities for collaboration. The NDEP has a highly effective campaign (ABC Campaign) that focuses on controlling A1c, blood pressure, and cholesterol. Expansion of the NDEP would yield greater impact by focusing on broader dissemination of campaign materials and messages, especially by targeting high risk minority populations.

Item

**Genomics** – The coming era of personalized medicine has broad applicability for the field of public health. The Committee urges CDC to conduct and sponsor public health genomics research and develop appropriate programs to identify people at risk for disease and early death. CDC is further urged to use genomic information to provide targeted and personalized interventions that will prevent disease, disability, and death, and may ultimately save public resources. (Page 69)

Action taken or to be taken

CDC is striving to invest in ways that enable genomic information to be used to improve the health of all Americans. Public health genomics can better reach health impact goals by effectively integrating genomics and family health history information, methodology, and technology into public health research, programs, and policies. Effective use of public health genomics can improve health outcomes through better, earlier, and more targeted interventions. Below are examples of CDC's of public health genomics activities.

**Integrating genomics into public health investigations:** Public health investigations are fundamental to CDC's mission to improve the health of the nation. People respond to various disease exposures differently due to genetic variation; some become sick and others do not. With adequate investment, human genomic specimens and data can be collected during these investigations, with the aim of identifying host risk factors for disease susceptibility, severity, and transmission. CDC is moving forward to begin to incorporate human genomics into public health investigations including those involving influenza, asthma, and birth defects.

**Genetics for early disease detection and intervention:** CDC is initiating and facilitating a collaborative effort to use clinical, genetic and family history information for early diagnosis of disease leading to improved health outcomes. A key component of this effort will be enhancing provider and public education about the genetic risk factors and symptoms for selected diseases.

**Assessing genetic tests for practice and prevention:** There are currently more than 1,000 genetic tests available to physicians, laboratories, and the general public. While this field offers great potential, currently little is known about the analytic validity, clinical validity, and clinical usefulness of these tests in practice. Some tests are being marketed directly to consumers in an unregulated marketplace. CDC is now investing in the capacity to conduct systematic reviews and evaluations to identify the pre- and post-market genomic applications that can make a significant health impact, by enabling better and more targeted interventions and treatments. CDC is working to provide information that can protect the public from invalid tests or applications with unsubstantiated claims. CDC is also working to build an infrastructure to monitor the health impact of genetic tests in populations.

**Development and use family history tools for prevention:** As a risk factor that reflects inherited genetic susceptibility as well as shared environment and behaviors, family history has untapped potential as a low-cost, "low-tech" genomic tool for public health and preventive medicine. To meet this need, CDC has developed a web-based tool, Family Healthware™, to enable health practitioners and the general public to more easily collect and benefit from family history, to better assess potential disease susceptibility, and to receive health messages that are appropriate to each person. CDC is now completing a clinical trial to validate the effectiveness of CDC's Family Healthware™ and to develop a stand-alone version of the software for broader application for health care use and for people without access to the Internet.

**Assessing and building capacity to apply genomics in public health:** Public health genomics laboratory, epidemiology, and programmatic capacity are needed in order to utilize genomic information to prevent disease through targeted interventions. Public health investment in this capacity lags significantly behind resources available for basic research. CDC is beginning to assess present resources and identify gaps and potential synergies that can be addressed across the agency.

Item

**Gynecologic cancer education and awareness program** – The Committee is encouraged by the progress that has been made by CDC, in coordination with the Office of Women's Health, to initiate a national education campaign on gynecologic cancers, working with qualified nonprofit private sector entities. The Committee strongly urges the continuation and expansion of this program, given that early detection can mean the difference between a 25 percent five-year survival rate and an 80 percent five-year survival rate for women diagnosed with a gynecologic cancer. The Committee also encourages CDC to conduct an examination of the coordination of HHS' current activities to educate women on gynecologic cancers. (Page 69/70)

Action taken or to be taken

CDC worked in collaboration with the Office of Women's Health and others to develop a detailed plan for implementing a National Gynecologic Cancer Awareness Campaign. The plan includes the dissemination of new and existing awareness materials, such as public service announcements and other educational materials about the signs and symptoms and early detection of gynecologic cancers. CDC has invited a panel of experts to participate in a meeting to be held February 2007 to: review current or existing strategies and activities for increasing awareness of gynecologic cancers, review consumer messages related to gynecologic cancers, identify potential areas for increasing reach of existing materials via broader dissemination, and identify potential areas for creating and providing additional or new information about gynecologic cancers to the public. Information and input from this meeting will be used to develop and modify new or existing consumer and health professional materials and messages for broad dissemination in Winter 2007.

Item

**Heart disease and stroke** – The Committee commends CDC for creating a division of heart disease and stroke prevention to consolidate and elevate efforts to prevent and control heart disease, stroke and other cardiovascular diseases. Given that cardiovascular diseases remain the number one killer in every state, the Committee continues to strongly believe that each state should receive funding for basic implementation of a state heart disease and stroke prevention program. Recognizing that many states still need this program, the Committee remains concerned that no new states have been added to this program since 2002. The Committee is aware that CDC is instituting an open competition, allowing non-funded states to apply for this program for the first time since 2002 and requiring all 33 funded states to re-compete for support. The Committee urges CDC to fund additional states for basic program implementation and add additional states to begin program planning for the state heart disease and stroke prevention program, maintain the Paul Coverdell national acute stroke registry, and, initiate the development of a state-based cardiac arrest registry. (Page 70)

Action taken or to be taken

Cardiovascular disease, including heart disease and stroke, remains the leading cause of death in the United States, affecting over 70 million Americans and costing the nation more than \$403 billion in direct and indirect health care costs per year. CDC remains committed to combating this disease. In FY 2007, CDC's Division for Heart Disease and Stroke Prevention will be conducting an open competition for state-based programs.

CDC continues to provide leadership in stroke treatment through the Paul Coverdell National Acute Stroke Registry. To date, 190 hospitals across four states are participating in a Coverdell stroke registry and approximately 30,000 patient cases have been collected. Analysis of collected data has shown sustained improvements among several of the performance measures. States are providing consultation and training to hospitals to achieve improvements across all of the performance measures by the end of the project period.

Finally, CDC is leading the development of the Cardiac Arrest Registry to Enhance Survival (CARES) program. The program is currently active in two metropolitan areas, with metro areas in 12 other states currently being recruited to participate. Efforts to date include the development of a web-based tool for EMS providers, dispatch centers, and hospitals to enter data for review and analysis by the national CARES. Current project activities are focusing on expanding the system to additional sites, developing survey tools to collect information on EMS providers, and providing training to sites on implementing their individual CARES programs.

Item

**Obesity** – The multiple factors contributing to the overweight and obesity epidemic took years to develop. Reversing the epidemic will require a long-term, well-coordinated, concerted approach to reach Americans where they live, work, play, and pray. Effective collaboration among the public, voluntary, and private sectors is critical to reshape the social and physical environment of our nation's communities and provide the necessary support, information, tools, and realistic strategies needed to reverse the current obesity trends nationwide. To effectively address this epidemic, the Committee encourages CDC to provide leadership and coordination for the federal government's efforts to address the overweight and obesity epidemic. (Page 70)

Action taken or to be taken

CDC recognizes that reversing the obesity epidemic will require a long-term, multi-faceted, coordinated, and comprehensive approach to reach Americans in all aspects of their lives. CDC is defining and implementing public health strategies to prevent and control obesity through the following activities:

**Developing an Agenda for Obesity Prevention and Control:** As part of recent strategic planning efforts, CDC is developing priorities for obesity prevention and control that support, inform, and contribute to development of a national public health plan on obesity prevention and control. CDC is using a systematic process to define how to provide strategic public health leadership for obesity prevention and control within CDC and for the nation. CDC is conducting a comprehensive examination of public health responsibilities and mandates, and convening appropriate public and private sector organizations and agencies at the federal and state levels to develop this leadership agenda.

**Enhancing Public-Private Partnerships:** In June 2006, over 100 leaders from organizations performing or funding activities related to healthy eating and active living met in Bethesda, Maryland. The major outcome of this meeting was the creation of the Healthy Eating Active Living Convergence Partnership (CP). CDC and the California Endowment joined the Robert Wood Johnson Foundation, the W.K. Kellogg Foundation and Kaiser Permanente on the CP steering committee. The Partnership's purpose is to work together to accelerate and support changes that promote healthy people in healthy places with an emphasis on policy change approaches. Key strategies include: 1) building support for healthy eating and active living policy at the national, state and local levels; 2) promoting and supporting connections within the healthy eating and active living field; 3) optimizing and increasing investments in community- and place-based initiatives; and 4) supporting innovations in the marketplace.

**Clinician Guidance:** During the past year, CDC collaborated with the Health Resources and Services Administration and the American Medical Association to convene an expert panel comprised of over 15 non-governmental provider agencies. The goal was to develop guidance for clinicians on the screening, prevention, and treatment for overweight children. This panel has reviewed the current literature and is drafting white paper recommendations on prevention, assessment, and treatment. These white paper recommendations will be finalized and published during 2007 in a peer-reviewed journal to inform practitioners on how to improve obesity care and management in children and youth.

**Integrating Nutrition and Physical Activity for Obesity Prevention and Control:** A strategic priority for obesity prevention and control efforts includes the integration CDC's Division of Nutrition and Physical Activity activities within and across CDC Centers and activities. This will require shared planning and leadership, resources, and accountability. Initial efforts over the next year will focus on planning and aligning resources to support and promote integration across functions.

Item

**Oral Health** – The Committee recognizes that to effectively reduce disparities in oral diseases efforts at state and local levels are critical. The Committee has provided funding to strengthen state capacities to target effective interventions, such as additional water fluoridation and school-linked sealant programs, and resources to the underserved, to assess trends in oral diseases, and to evaluate changes in policies and programs to reduce the disease burden. The Committee encourages CDC to advance efforts to reduce the disparities and health burden from oral diseases that are closely linked to chronic diseases such as diabetes and heart disease. (Page 70)

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, support 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. PH causes deadly deterioration of the heart and lungs and is a secondary condition in many other serious disorders such as scleroderma and lupus. Because early detection of PH is critical to a patient's survival and quality of life, the Committee continues to encourage CDC to work in partnership with the pulmonary hypertension community to foster greater awareness of the disease. (Page 71)

Action taken or to be taken

CDC continues to develop ways to communicate information about pulmonary hypertension (PH) through its website and provides links to websites of other appropriate medical, public health and volunteer organizations that address PH. States that receive CDC funding for the prevention of heart disease and stroke are encouraged to work with local and state-level PH organizations and other groups to build awareness of the disease. CDC will also continue to provide information on PH, as well as information on collaborating with PH organizations, to all states via routine communications.

Item

**Sleep disorders** – The Committee continues to be concerned about the prevalence of sleep disorders and recognizes the need for enhanced public and professional awareness on sleep and sleep disorders. The Committee continues to urge CDC to work with other agencies and voluntary health organizations to support and implement a sleep education and public awareness initiative. The Committee also urges CDC to increase support for initiatives connecting sleep to overall health and safety. (Page 71)

Action taken or to be taken

Surveillance conducted at CDC indicates that sleep insufficiency is associated with impairments in both quality of life and self reported general health, and, notably, that the strength of these associations varies inversely with age. CDC analyzed data from a Behavioral Risk Factor Surveillance System (BRFSS) module specifically assessing relevant health risk behaviors, which will help researchers to address the complex interrelationship between sleep and health. CDC participated in the Frontiers in Knowledge in Sleep and Sleep Disorders program and the State of the Science Conference of Manifestations and Management of Chronic Insomnia in Adults, both sponsored by the National Institutes of Health (NIH). CDC serves in an advisory capacity as an ex officio member of the Sleep Disorders Research Advisory Board coordinated by the National Heart, Lung, and Blood Institute within NIH. CDC also participates in the National Sleep Awareness Round Table, a group comprised of agencies across the United States that focus on raising awareness on the importance of sleep.

Item

**Alpha-1 antitrypsin deficiency** – The Committee is aware that Alpha-1 antitrypsin deficiency (Alpha-1) is the major genetic risk factor for chronic obstructive pulmonary disease (COPD) and cryptogenic liver disease. Early detection allows individuals to engage in preventative health measures and receive appropriate therapies which significantly improve their health status. In addition, utilization of well defined disease management programs significantly reduces exacerbations and health care costs. The Committee encourages CDC to develop a partnership with appropriate patient and professional organizations to actively support Alpha-1 targeted detection efforts that utilize public and professional education regarding obstructive lung disease, both genetic and tobacco related. (Page 72)

Action taken or to be taken

CDC shares the Committee's concern regarding Alpha-1 antitrypsin deficiency (Alpha-1) as a major genetic risk factor for chronic obstructive pulmonary disease (COPD) and cryptogenic liver disease. CDC is not actively involved in public screening and detection for Alpha-1 Antitrypsin Deficiency. CDC agrees that supporting new collaborative efforts could address public health needs related to this deficiency.

Item

**Blindness** – The Committee is concerned that people with vision impairment and blindness have a significant unmet need for appropriate public health interventions and information to prevent further impairment and disability. The lack of such appropriate interventions has resulted in people with vision loss having higher rates of depression, hypertension, heart disease, stroke, and physical injuries than people without sensory impairments. The Committee urges additional evidence-based research for effective public health interventions, as well as the national dissemination of these interventions through a website and other means accessible to the blind and visually impaired. The Committee urges CDC to launch this initiative and 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.

Action taken or to be taken

CDC has published a series of papers addressing health disparities comparing people with and without vision loss. CDC is further developing this foundation of knowledge by supporting a special issue of the Journal of Visual Impairment and Blindness on the public health of vision loss. This collection of essays identifies opportunities for public health to gain additional knowledge about the health and health behaviors of people with vision loss and

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potential strategies to improve health and health promotion through interventions and information dissemination. This special issue will be available in February 2007 and will be publicly available on the American Foundation for the Blind website.

Item

**Cerebral palsy** – The Committee encourages CDC to establish cerebral palsy surveillance and epidemiology sites throughout the United States based on methodology developed in the Metropolitan Atlanta Developmental Disabilities Study and the Metropolitan Atlanta Developmental Disabilities Surveillance Program. The Committee encourages CDC to build upon the infrastructure established for the autism developmental disability monitoring sites and the centers for autism and developmental disabilities research and epidemiology sites and to establish surveillance and epidemiology centers for cerebral palsy as was done for autism. (Page 73)

Action taken or to be taken

In 2002, two of CDC's autism and developmental disability monitoring sites expanded to include cerebral palsy and epidemiology at their locations. In 2006, the number increased to three sites. CDC anticipates that, as the surveillance network matures, additional sites will be added.

Item

**Cooley's anemia** – The Committee remains pleased with the progress that CDC has made with regard to the establishment of a blood safety surveillance program for Cooley's anemia patients, who are the largest consumers of red blood cells. Six treatment centers throughout the Nation handle the medical monitoring and treatment; a private foundation provides education and awareness, patient recruitment, and other services; and, CDC has created an archive of tested and analyzed blood samples. The Committee urges CDC to utilize this program to enhance the safety of the blood supply while improving the health of Cooley's anemia patients. (Page 73)

Action taken or to be taken

CDC remains committed to monitor blood safety and reduce complications among person with thalassemia, including Cooley's anemia, using the successful CDC National Hemophilia Program as a model. In doing so, CDC increases access to prevention services for persons with thalassemia by supporting prevention education and outreach activities. The program has demonstrated a high degree of commitment to providing outreach in underserved populations, particularly those of Asian origin. Greater than 50% of patients seen at the Thalassemia Treatment Centers have been enrolled and blood specimens are continually tested and banked at CDC. Blood safety investigations have been conducted and to date there have been no documented transfusion related HIV or hepatitis sero-conversions. CDC has expanded the blood safety surveillance program in thalassemia to collect information on other complication risk factors including iron overload, cardiac and liver disease, fertility, and endocrinopathies.

Item

**Down syndrome** – The Committee encourages CDC to continue its research on the secondary and related developmental and mental disorders in individuals with Down syndrome that it began in fiscal year 2005. (Page 73)

Action taken or to be taken

CDC has conducted studies of secondary and related developmental and mental disorders among individuals with Down syndrome (DS). To date, little is known about the interaction between DS and autism spectrum disorders. Obtaining reliable estimates might be compromised by the unique challenges posed by screening children with DS for autism spectrum disorder symptoms. The two studies will provide insight into population-based prevalence estimates for these conditions and appropriate diagnostic tools for use in clinical settings. In addition, CDC is conducting an analysis of National Health Interview Survey data which will provide national, population-based data that further the current understanding of the range of health and health care issues faced by children with DS so that more effective prevention and intervention strategies can be developed.

Item

**Duchenne and Becker muscular dystrophy (DBMD)** – The Committee is pleased that CDC developed and submitted its Duchenne and Becker Muscular Dystrophy Strategic Plan to Congress. To ensure the goals of this plan are achieved by the intended deadlines, the Committee provides funding to expand the existing surveillance, epidemiological, and education initiatives and to establish a nationwide DBMD patient registry by July 1, 2007. The Committee believes a nationwide DBMD patient registry will build upon the existing surveillance work and ensure the data gathered are deposited in one centralized repository. Additionally, to help ensure adequate patient data are collected, the Committee strongly urges CDC to expand the muscular dystrophy surveillance tracking and research network by one additional site in 2007. The Committee continues to be pleased with the work being done through the

joint public/private education and outreach cooperative agreement and would encourage that additional funds be used to continue and expand this program. The Committee is pleased that CDC is working with the Agency for Healthcare Research and Quality to establish evidence-driven standards of care for DBMD patients, and encourages both agencies to complete this work by February 1, 2007. (Page 73)

Action taken or to be taken

CDC appreciates the Committee's acknowledgment of the agency's work with respect to Duchenne and Becker Muscular Dystrophy. CDC is currently working with national and international partners to assess the feasibility of establishing a nationwide patient registry and agrees such a registry would be an important asset to research and practice. With regard to the agency's Muscular Dystrophy Surveillance Tracking and Research Network, CDC hopes to expand this program by funding an additional site. Finally, CDC shares the Committee's concern regarding the lack of evidence-driven standards of care. CDC staff is serving on a steering committee along with representatives from the Agency for Healthcare Research and Quality, Parent Project Muscular Dystrophy, Muscular Dystrophy Association, and academic institutions in order to advance work in this area by utilizing established methods to synthesize information from scientific literature and expert opinions regarding evidence-driven standards of care.

Item

**Fragile X** – The Committee is encouraged by CDC's efforts related to Fragile X and support for the Fragile X public health program to expand surveillance and epidemiological research of Fragile X. Given the limited resources available, the Committee urges CDC to ensure that the agency's educational and awareness activities under this initiative are not duplicative of current efforts of nationally recognized authorities in the area of Fragile X, but are instead focused on supporting the further dissemination and distribution of existing informational materials. (Page 74)

Action taken or to be taken

CDC agrees that efforts related to Fragile X (FX) awareness should be effectively coordinated with FX voluntary groups. The agency continues productive collaborations with nationally recognized authorities on FX, including the National Fragile X Foundation, to disseminate information to healthcare providers and the general public. For example, expanded FX guidelines were recently developed through focused advisory meetings of authorities on FX. These guidelines are currently being disseminated through publication in various peer-reviewed journals, postcard mailings to healthcare providers in specific medical disciplines (i.e. neurology, psychiatry, obstetrics/gynecology), and presentations at conferences held by professional medical societies.

Item

**Hereditary hemorrhagic telangiectasia (HHT)** – HHT, also known as Osler-Weber-Rendu syndrome, is a multi-system vascular genetic disorder producing blood vessel malformations in the brain and lung which may result in stroke, hemorrhage, aneurysm and death. Sudden death or disability may occur in 20 percent of children and adults, but is largely preventable with proper intervention. The Committee encourages CDC to establish, through a joint initiative with the HHT treatment centers, effective evidence-based interventions and treatment to improve outcomes and the quality of life for people living with HHT. (Page 74)

Action taken or to be taken

CDC met with the Hereditary Hemorrhagic Telangiectasia (HHT) Foundation in March 2006. An additional meeting was held in October 2006. CDC and the HHT Foundation identified several opportunities for collaboration and mutual assistance for improving knowledge of this condition as well as evidence-based interventions and treatment.

Item

**Marfan syndrome** – The Committee continues to be interested in Marfan syndrome, a progressive and degenerative genetic disorder which can result in sudden loss of life from aortic aneurysms. Unfortunately, many individuals affected by Marfan syndrome are undiagnosed or misdiagnosed until they experience a cardiac complication. Increasing awareness of this life-threatening disease is vital to ensuring accurate diagnosis and appropriate disease management in patients who are at risk for cardiovascular complications. The Committee encourages CDC to partner with the Marfan syndrome community to increase awareness of the disease among the general public and health care providers. (Page 74)

Action taken or to be taken

CDC is aware of the public health concerns regarding Marfan syndrome and shares the Committee's concerns. CDC is not actively involved in efforts related to Marfan syndrome but agrees that partnering with the community could increase awareness of the disease among the general public and health care providers.

Item

**Spina bifida** – The Committee recognizes that spina bifida is the leading permanently disabling birth defect in the U.S. While spina bifida and related neural tube defects are highly preventable through proper nutrition, including appropriate folic acid consumption, and its secondary effects can be mitigated through appropriate and proactive medical care and management, such efforts have not been adequately supported or coordinated to result in significant reductions in these costly conditions. In an effort to continue to improve the quality-of-life for individuals affected by spina bifida and reduce and prevent the occurrence of, and suffering from, this birth defect, the Committee encourages CDC to coordinate with the appropriate health organization to promote the prevention of spina bifida and to enhance the lives of all affected. Within the funds provided for spina bifida, the Committee supports the maintenance and continuation of the national spina bifida clearinghouse and resource center to meet the current and growing demand for information and support services for individuals and families affected by spina bifida. In addition, the Committee supports the Memorandum of Understanding between CDC and the Agency for Healthcare Research and Quality to examine clinical treatment of spina bifida and improve quality of life. (Page 74/75)

Action taken or to be taken

CDC continues programs to promote maternal folic acid consumption and to promote the health and well-being of children and adults living with spina bifida. CDC continues to support the national spina bifida clearinghouse and resource center as well as other information and support activities provided by the Spina Bifida Association. In addition, CDC is continuing to collaborate with the Agency for Healthcare Research and Quality to establish a spina bifida clinic registry for the purposes of improving care and advancing understanding of interventions that will improve health and quality of life for children and adults living with spina bifida.

Item

**Tuberous sclerosis complex (TSC)** – TSC is a genetic disorder that causes uncontrollable tumor growth. Because this disorder can affect multiple organs of the body, it is difficult to diagnose, track and properly treat. The Committee encourages CDC to develop a joint initiative with an appropriate health organization to collect and analyze data from the nationwide network of TSC clinics; support surveillance and epidemiological studies; and to educate health care professionals and teachers who come into contact with TSC patients. (Page 75)

Action taken or to be taken

CDC shares the Committee's concern regarding tuberous sclerosis complex (TSC). CDC looks forward to meeting with relevant organizations to discuss the public health approach to TSC. Funding at the level proposed by the House Committee for FY 2007 could allow CDC to undertake activities such as surveillance, epidemiological studies and awareness as part of a public health response to this issue.

Item

**Nontuberculous mycobacteria (NTM)** – The Committee is concerned that NTM incidence continues to rise. Mycobacteria are environmental organisms found in both water and soil that cause substantial respiratory damage. The Committee encourages the national center for health statistics to include questions regarding NTM testing in ongoing surveys to gain a better understanding of the epidemiology of this emergent disease. (Page 76)

Action taken or to be taken

Because testing for nontuberculous mycobacteria (NTM) is not part of standard clinical practice, individuals are unlikely to be aware of possible exposure to NTM. As part of CDC's National Health and Nutrition Examination Survey, however, skin tests for NTM were conducted in the early 1970s and in 1999-2000. The resulting data, which reveal possible exposure to antigens and cannot be used to determine whether a person is ill due to a particular disease, were released on public use files for analysis by interested researchers.

Item

**Psoriasis** – The Committee urges NCHS to ensure that any data collected on psoriasis be comprehensive and include the full age range of individuals affected by the disease including children, adolescents, and adults. The Committee is interested in having NCHS collect and report psoriasis incidence and prevalence data that are based on nationwide epidemiological studies. If such data are not currently available, the Committee urges NCHS to undertake a comprehensive epidemiological study with a focus on determining incidence of psoriasis and psoriatic arthritis. The Committee urges CDC to consider working with a national psoriasis organization to develop a surveillance program to ascertain and monitor psoriasis and psoriatic arthritis and co-morbidities. (Page 76)

Action taken or to be taken

The National Health and Nutrition Examination Survey (NHANES) has collected data on psoriasis since 2003. Three questions about psoriasis, developed with input from the National Psoriasis Foundation, have been asked of survey participants ages 20 - 59. These questions ask whether the participant has ever been told by a health professional that he/she had psoriasis, how much of a problem the psoriasis has been in daily life, and how extensive the psoriasis is. These data provide estimates of psoriasis and severity for the United States population ages 20 - 59. This data collection was planned and funded in collaboration with NIH's National Institute of Arthritis and Musculoskeletal and Skin Diseases and continued through 2006. A preliminary estimate of prevalence from the 2003-2004 sample shows that the prevalence is relatively low in the population.

- The crude overall prevalence for adults ages 20-59 is 3.14 percent.
- For non-hispanic white women ages 20-59, the prevalence is 3.45 percent.
- For non-hispanic white men ages 20-59, the prevalence is 4.06 percent.

Currently CDC does not have data on psoriatic arthritis. Although some CDC surveys obtain data on arthritis, the surveys do not ask specifically about psoriatic arthritis. These surveys are conducted on small samples of the population, making it difficult to capture reliable information on health conditions, such as psoriatic arthritis, that occur relatively infrequently in the population.

Item

**Asthma** – The Committee is pleased with the work that CDC has done to address the increasing prevalence of asthma. However, the increase in asthma among children remains alarming. The Committee urges CDC to continue 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. (Page 77)

Action taken or to be taken

CDC's asthma control program is further expanding its outreach aimed at increasing public awareness of asthma control and prevention strategies, particularly among at-risk populations in underserved communities. This year, through its National Asthma Health Education Enhancement effort, CDC has funded voluntary health organizations such as the Allergy and Asthma Network/Mothers of Asthmatics, American Lung Association (ALA), and Asthma and Allergy Foundation of America to conduct activities related to asthma education. These activities range from identifying effective educational programs for adults that can be adapted for nationwide use to educating children with asthma and their families and caregivers. CDC created a web site called "Effective Interventions for Asthma Control" for state and local public health organizations and other partners to assist in efforts to determine what has been evaluated and best practices. This website provides access to interventions and other materials for partners to adapt and implement related to controlling and managing asthma.

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

CDC is also currently funding two national nongovernmental organizations (ALA and American Association of School Administrators) to provide capacity building assistance to faith-based institutions, youth service providers, or parent organizations interested in addressing asthma in schools. Activities include funding community-based approaches to comprehensive asthma management in schools, highlighting promising practices, and providing opportunities for state-level collaboration to support leadership and expertise around childhood asthma.

All of CDC's partners funded for school health activities use CDC's research-based document, "Strategies for Addressing Asthma Within a Coordinated School Health Program," released in Fall 2002, to guide their programs. CDC's new version of its popular "School Health Index: A Self-Assessment and Planning Guide" includes asthma information and provides helpful guidance to funded partners on ways to use research-based strategies to address asthma in schools. Also, CDC's newly updated "Resources for Addressing Asthma in Schools" highlights several publications and websites developed by national organizations, including the Center for Health Care Strategies, RAND Corporation, the American Academy of Pediatrics, and the American Academy of Allergy, Asthma, and Immunology.

Item

**Biomonitoring** – The Committee applauds the CDC's biomonitoring efforts and encourages the agency to continue this program and continue to improve its efforts to communicate these results in context. In particular, the CDC's National Report on Human Exposure to Environmental Chemicals is a significant new exposure tool that provides invaluable information for setting research priorities and for tracking trends in human exposures over time. Accordingly, the Committee continues to support the CDC environmental health laboratory's efforts to provide exposure information about environmental chemicals. However, as CDC has recognized, this information does not by itself suggest harmful effects in humans. In fact, for most chemicals, it is currently difficult to interpret biomonitoring information in a health risk context. Therefore, the Committee encourages CDC to collaborate with federal government and private sector toxicologists, health scientists and laboratory analytical chemists, to facilitate the development of the necessary methods to interpret human biomonitoring concentrations in the context of potential health risks. (Page 77)

Action taken or to be taken

Currently, CDC is works with 50 partners , including federal agencies (e.g., EPA); state health departments (e.g., California, New York, New Jersey, Nevada, Arizona, New Hampshire, New Mexico) academic institutions (e.g., Harvard School of Public Health, Columbia University, Mt. Sinai Medical Center, the University of California at Berkeley, the University of Missouri at Columbia, University of Iowa and the University of Wisconsin at Milwaukee) and private -sector groups on human exposure studies that attempt to determine whether an association exists between people's exposure to a particular chemical and an adverse health effect. In FY 06, CDC conducted 52 such studies, including studies of human exposure to heavy metals (e.g., mercury), pesticides, personal-care products, and volatile organic compounds. Results of these studies contribute to the growing body of knowledge about people's exposure to environmental chemicals. In addition, CDC's Environmental Health Laboratory will release its Fourth National Report on Human Exposure to Environmental Chemicals in 2007; the Report will contain exposure data by age, sex, and race/ethnicity on at least 250 environmental chemicals found in the general U.S. population.

Item

**National Environmental Public Health Tracking Network** – The National Environmental Public Health Tracking Network seeks to expand the program to monitor, link, and assess environmental and health data to identify problems and effective solutions that will reduce the burden of chronic and other non-infectious disease in the American population. 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. A critical component of the program is to ensure that various stakeholders, especially communities, are engaged in the process of developing the state networks and ultimately the network. Therefore, the Committee urges CDC and the State and local programs take actions to include communities and other stakeholders in the development and implementation of the tracking network. (Page 78)

Action taken or to be taken

CDC is continuing to take specific steps in its National Environmental Public Health Tracking Program (referred to as Tracking Program) to ensure that communities are engaged in the process of developing the national and state- based networks. For example, in June 2004, 50 stakeholders of the national program met to discuss progress, successes, and challenges of the program's first 2 years, and future activities. Stakeholders included representatives from academia, community advocacy groups, the faith-based community, local and state health departments, federal health and environmental agencies, and national environmental, industry, medical, and public health organizations. The meeting was designed to give CDC's external partners, including community representatives, an opportunity to provide direct input to the program.

In August 2005, CDC's Tracking Program convened its second annual conference. Through its partnership with the Trust for America's Health (TFAH), CDC awarded 20 scholarships to representatives of community-based organization from across the country. These participants gave presentations and exhibited at the conference to increase the awareness of the importance of community groups in CDC's Tracking Program. The TFAH Staff Outreach Associate also served on the planning committee for the conference to represent the voice of this vital stakeholder.

From 2002-2006, funded state and local health departments were required to establish advisory groups or planning consortiums that included not only technical experts, but community members and other key stakeholders. Planning consortiums collaborated with the health department grantees in determining health and environmental data priorities for the state or city. The Tracking Program is now working to implement the Tracking Network and state/local networks based on these priorities. Current implementation grants to 16 states and New York City require that health departments collaborate with stakeholder organizations to identify common needs, promote resource and information sharing, and facilitate public health actions to improve the health of communities.

CDC is currently expanding its outreach strategy to incorporate current network implementation activities. This strategy will be finalized in late FY07 and deployed in FY08. One key component of this strategy is a second stakeholder dialogue to further the work started by the 2004 meeting.

Item

**Child maltreatment** – The Committee applauds CDC's activities in the areas of child maltreatment. A growing body of research indicates that childhood abuse and neglect may contribute significantly to the development of both acute and chronic health conditions throughout the lifespan, including obesity and heart disease. The Committee encourages CDC to develop a network of consortia that will address research and training, as well as the dissemination of best practices and prevention efforts, on the health harms of child abuse and neglect. (Page 78)

Action taken or to be taken

CDC recognizes that child maltreatment can impact the development of the brain of a child and subsequently increase vulnerabilities to a broad range of mental and physical health problems, ranging from anxiety disorders and depression to cardiovascular disease and diabetes. Safe, stable, and nurturing relationships with parents and other significant adults build healthy brains that provide a strong foundation for healthy development. CDC supports the development and dissemination of (1) prevention strategies designed to empower parents; (2) positive parenting, caregivers, and families; and (3) social environments that value and support children. The promotion of effective child maltreatment prevention programs will enhance health and well-being across the lifespan.

CDC is committed to advancing the science of prevention for child maltreatment, with a focus on translating scientific advances into practical application through effective programs and policies. CDC will examine the best ways to ensure that pediatricians, nurses, day care providers and other people important in the lives of families have the best training and most effective strategies to ensure that parents and children thrive in our communities. CDC will encourage relationships between child maltreatment prevention programs and academic institutions, teaching hospitals, injury prevention organizations and other groups to share and disseminate knowledge.

CDC is implementing the Building and Enhancing Community Alliances United for Safety and Empowerment (BECAUSE) Kids Count! program to expand the capacity of national organizations and their state, local, regional, or tribal affiliates to address child maltreatment prevention. CDC is funding the BECAUSE grantees to expand their leadership role in addressing the prevention of child maltreatment by disseminating the key concepts of primary prevention, evaluation, models for community assessment and action, and evidence-based prevention strategies within the organizations. This work will foster effective organizational collaborations that can respond to emerging policy and program issues related to the prevention of child maltreatment and assist in dissemination of information and results as promising and proven prevention strategies are determined.

Item

**Botulinum neurotoxin research** – The Committee requests that CDC submit a plan to accompany the fiscal year 2008 President's budget request to Congress to participate and share in the development of advanced in-vitro and cell-based fluorescence resonance energy transfer assays for the detection and classification of botulinum neurotoxins being developed by the United States Army's Medical Research Institute of Chemical Defense. The plan should identify how the Army program can be leveraged to meet CDC requirements and how CDC will participate in co-development of the assay. (Page 80)

Action taken or to be taken

The FY 2007 President's Budget request includes funding for Botulinum neurotoxin research. However, CDC's FY 2007 budget is pending Congressional action. The Agency looks forward to addressing this item when the FY 2007 budget is final.

Item

**Strategic National Stockpile** – The Committee recognizes that, in the wake of the Gulf Coast hurricanes of 2005, CDC is considering how to reconfigure the strategic national stockpile to fulfill a broader disaster response mission. Psychotropic medications such as anti-psychotic, anti-depressant and anti-seizure medications are widely prescribed and critical to the quality of life of those who take them. Moreover, the sudden deprivation of these drugs, particularly in the wake of trauma and stress of a disaster, can create major mental illness management challenges for emergency responders, diverting crucial resources and impeding recovery. For these reasons, the Committee strongly encourages the CDC to include psychotropic medications in a reconfigured strategic national stockpile. (Page 80)

Action taken or to be taken

HHS and CDC have conducted reviews of the pharmaceutical and special needs requirements generated during the response to the Gulf Coast Hurricane season of 2005. As a result, HHS updated the formulary of the Federal Medical Stations (FMS) to include selected pharmaceuticals and special needs items that were required to successfully support the response; HHS and CDC continue to review and refine the FMS formulary. A FMS is a 250- bed, non-acute care, temporary deployable platform. Additionally, supply lines with prime vendors have been established to ensure availability of required chronic disease pharmaceuticals and special needs items during an emergency response.

The CDC's National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) developed an action guide for state and local leaders to use in planning for and responding to the needs of chronically ill persons during an emergency response. This guide is currently being reviewed for release and will be available upon its approval as required.

Officials in HHS' Office of the Assistant Secretary for Preparedness and Response (ASPR) have collaborated with the CDC's Coordinating Office for Terrorism Preparedness and Emergency Response (COTPER) to establish procedures for an all hazards perspective for the periodic review and evaluation of the medications maintained or recommended for inclusion in the Strategic National Stockpile (SNS). It is the charge of this enterprise to ensure that the SNS is equipped to best meet the nation's public health emergency needs.

Item

**[Performance metric - preparedness goals]** – . . . . The Committee also recognizes that HHS has incorporated the National Preparedness Goal into the cooperative agreement guidance and established new CDC Preparedness Goals. The Committee urges the Department to assure that the performance metrics for the CDC Preparedness Goals, by which local health department preparedness will be measured, are fully consistent with the target capabilities list of the National Preparedness Goal. (Page 166)

Action taken or to be taken

The performance metrics for the Public Health Emergency Preparedness Program for FY 2007 are based upon an inclusive discussion with grantees and other stakeholders. Aspects of each measure, such as its actual utility as a reflection of preparedness or progress, the ease and reliability of reporting the measure, and its usefulness for comparisons over time and across grantees are under review and refinement. A measurement framework in which the grantees report performance metrics is based on their annual workplans, the CDC Preparedness Goals, the Target Capabilities related to each, and their associated critical tasks.

**SIGNIFICANT ITEMS IN APPROPRIATIONS REPORTS SENATE**

**SIGNIFICANT ITEMS FOR INCLUSION IN  
THE FY 2008 CONGRESSIONAL JUSTIFICATION  
AND OPENING STATEMENTS  
SENATE REPORT NO. 109-287**

**CENTERS FOR DISEASE CONTROL AND PREVENTION**

Item

**Hepatitis** – The Committee continues to be concerned that more than many of the people infected with hepatitis C are unaware of their condition. The Committee encourages CDC to collaborate with national voluntary health organizations to raise awareness of appropriate screening and medical follow up of target populations. The Committee is also aware of increasing rates of hepatitis A and B infections among select adult populations, as well as the alarming rate of individuals co-infected with both hepatitis C and HIV. The Committee encourages CDC to aid hepatitis screening initiatives in the States; help establish guidelines and recommendations for preemptive programs; consider focusing on education and awareness programs targeted at specific populations where there is a high prevalence of hepatitis B and where therapeutic interventions are increasingly effective; and implement the National Hepatitis C Prevention Strategy to address the emerging threat of hepatitis C. In addition, the Committee strongly urges CDC to collaborate with the Health Resources and Services Administration to implement improved HCV screening programs for HIV-infected individuals served by HRSA programs. (Page 71/72)

Action taken or to be taken

Awareness of infection status has increased significantly from the 1990s, when only 25% of hepatitis C virus (HCV)-infected persons had knowledge of their infection. However, approximately half of HCV-positive individuals remain unaware of their infection status and, therefore, of their potential risk for serious liver disease or liver cancer. During FY 2006, CDC funded seven organizations to develop, evaluate, and distribute educational materials on viral hepatitis for health professionals, patients, and the public. These and other informational materials are also available online, and in 2006, approximately 600,000 persons used the Internet to access this information about viral hepatitis. CDC works with the National Viral Hepatitis Roundtable, whose member organizations have developed educational materials and campaigns to increase knowledge and awareness of hepatitis. CDC also works with the American Medical Association to develop national standards for the diagnosis and treatment of HCV. To improve collaboration with the Health Resources and Services Administration, the CDC/HRSA Advisory Committee on HIV and STD Prevention and Treatment has offered to advise both agencies regarding collaborative efforts to improve prevention and control of viral hepatitis.

In FY 2006 and FY 2007, CDC issued new recommendations to guide hepatitis A (HAV) and hepatitis B (HBV) vaccination. The implementation of routine childhood and adolescent vaccination, supported by federal programs, has resulted in large reductions in the incidence of acute HBV. However, in the absence of a national vaccination program for adults, vaccination coverage among adults at risk for HBV infection remains low. In FY 2007, CDC encouraged all state and local health agencies to use Section 317 funds to increase their support for adult HBV vaccination. CDC also supports organizations to produce and disseminate culturally appropriate educational materials for a variety of ethnic populations at increased risk for HBV. Reflecting the value of new treatments for infected persons and vaccination of their close contacts, CDC has also issued guidance to help immunization programs identify and manage persons with chronic hepatitis. In FY 2007, CDC will convene a consultation of experts in viral hepatitis prevention and care to help the agency prepare similar guidance for other health settings.

In FY 2007, CDC plans to issue a request for proposals to fund viral hepatitis coordinators to promote implementation of the National HCV Prevention Strategy and the adoption of other activities to improve the delivery of viral hepatitis prevention services in health-care settings and public health programs that serve adults at risk for viral hepatitis. Successful proposals will be funded to decrease the incidence of new infections of HAV, HBV and HCV (primary prevention) and to decrease risks for chronic liver disease, including cirrhosis and liver cancer, among persons with chronic HBV infection or chronic HCV infection (secondary prevention).

Item

**Tuberculosis** – The Committee understands that TB is an enormous health crisis in the developing world, killing 2 million people every year. Despite the development of effective treatments against TB 50 years ago, there have never been more people infected with the disease in the history of the world. The Committee encourages CDC to continue and, if possible, expand the existing TB vaccine research cooperative agreement. (Page 73)

Action taken or to be taken

CDC awarded a cooperative agreement to the Aeras Global Tuberculosis Vaccine Foundation (Aeras) in September 2004. This cooperative agreement has provided training programs and materials including specialized training for establishing local human subjects review capacity according to international standards. It has also provided epidemiologic and technical assistance in the development of clinical trials training programs that include good clinical practice guidelines and ethical standards. CDC has provided technical assistance including assisting in the development of laboratory capacity and referral systems to treat and cure patients with TB, developing protocols for epidemiologic studies, observational cohort studies, and refining information on TB prevalence and incidence in neonatal and adolescent cohorts in the trials site.

Item

**Tuberculosis** – The Committee understands that the CDC is planning a new initiative called the Intensified Support and Activities to Accelerate Control [ISAAC]. ISAAC plans call for targeting TB in African Americans and along the U.S./Mexico border, universal genotyping of all culture positive TB cases, and expanding clinical trials and development of new tools for the diagnosis and treatment of TB. The Committee encourages the CDC to implement ISSAC to accelerate the control and elimination of TB. (Page 73)

Action taken or to be taken

In FY 2004, the National Coalition for the Elimination of Tuberculosis proposed a new initiative: Intensified Support and Activities to Accelerate Control (ISAAC). The initiative, which would require additional funding of \$105 million to implement, aims to sustain the momentum of the past 10 years and accelerate the control and elimination of tuberculosis in the United States. The initiative's TB control activities include reducing the disproportionately high rates of TB in African Americans, addressing TB along the US-Mexico Border, intensifying universal genotyping, and conducting research to improve TB diagnosis and treatment of TB.

CDC, both directly and through its partnership with State and local governments, uses its appropriation for TB control to address the same goals.

In 2006, CDC held a "Stop TB in the African American Community Summit," designed to raise awareness of the TB problem in the African American community and to foster collaborations and partnerships to address the problem. More than 100 representatives from TB prevention programs, professional organizations, academia, advocacy organizations, and other groups attended and discussed strategies. In addition, a Stop TB in the African American Community listserv and a website have been developed.

Along the border, CDC works closely with the World Health Organization (WHO), the Pan American Health Organization (PAHO), Mexico, the U.S.-Mexico Border Health Commission, and the four U.S. Border States of California, Arizona, New Mexico, and Texas to conduct case management, administer directly observed therapy, follow-up on persons exposed to TB disease, and provide support for laboratory services for diagnosis.

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

Finally, CDC is analyzing data on recently developed tools for rapidly diagnosing TB. In FY 2006, CDC issued guidelines for using one such tool – the TB Quantiferon TB Gold test in public health practice. CDC also issued guidelines for prevention and control of TB in correctional settings and detention centers and guidelines for preventing TB among health care workers, patients and their families.

Item

**Tuberculosis** – In fiscal year 2006, the Committee encouraged the CDC in the Senate report to make available funds to States suffering from TB cases among recently-arrived Hmong. The Committee understands the CDC and Department of State still have not adequately contained the TB outbreak in the Thailand refugee camp and serious TB control problems have recently become apparent, including long delays in lab testing and an absence of oversight of complicated multi-drug resistant TB cases. As a result, TB importation with Hmong newcomers has continued through December 2005. The Committee again encourages additional funding through CDC's cooperative agreements to help States respond to the TB epidemic among this population. The Committee recognizes the

importance of Transitional and Medical Services funding under the Refugee and Entrant Assistance Program to specifically target the TB medical care needs of this population. (Page 74)

Action taken or to be taken

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

Item

**[Purchase of vaccines for the State of Alaska's immunization program]** – The Committee encourages CDC to increase section 317 grant support for infrastructure development and purchase of vaccines for the State of Alaska's universal immunization program. It has been brought to the Committee's attention that infrastructure costs of delivering vaccines to children in Alaska are substantially higher than in other areas of the country, because of the many small, remote communities which must be served primarily by air. The Committee encourages the agency to give careful consideration to Alaska's request for sufficient funding for the purchase of vaccines needed for 90 percent of Alaskan children and to provide infrastructure support needed to deliver these vaccines at the community level, including development of a statewide immunization registry to ensure that all children in Alaska are immunized. The Committee notes that failure to immunize children in remote areas of Alaska results in deaths each year from exposure to open sewage lagoons and contaminated water. (Page 76)

Action taken or to be taken

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

Item

**Assay Standardization** – The Committee commends the CDC for its efforts to standardize assays that are essential for research on the causes and prevention of type 1 diabetes. Standardized methods to measure diabetes autoantibodies improve the prediction of disease risk in vulnerable individuals, enable direct comparisons of new therapies in clinical trials, and facilitate the exchange of data within the research community. The CDC is encouraged to expedite development of a standard assay for C-peptide, which the Committee is aware may serve as a biomarker and reduce the length of clinical trials for new drugs to prevent or reverse type 1 diabetes. (Page 77)

Action taken or to be taken

Through an interagency agreement with the National Institute of Diabetes and Digestive and Kidney Diseases, NIH, CDC will collaborate with the University of Missouri via a contract to conduct a program to identify and minimize measurement problems to standardize and improve the measurement of C-peptide. This program will 1) evaluate the variability among diabetes research laboratories that analyze C-peptide and 2) examine the possibility of harmonizing C-peptide assays to allow comparison of results across laboratories. In addition to laboratories currently analyzing C-peptide for Diabetes Prevention Trial for Type 1 Diabetes and the Type 1 Diabetes TrialNet, other national and international laboratories will be invited to participate in this study. Laboratories will be surveyed to obtain general assay information (i.e., type of methods, source of calibration, detection limits, test ranges, known interference, sample stability) and available laboratory quality control data. By standardizing C-peptide measurements, CDC will ensure that physicians are using the most accurate measurements to make clinical decisions.

Item

**Chronic Obstructive Pulmonary Disease** – Chronic obstructive pulmonary disease [COPD] is the fourth leading cause of death in the United States and the only one of the top 10 causes of death that is on the increase. The Committee encourages the CDC to expand its data collection efforts on COPD. Specifically, the Committee encourages the CDC to include questions on COPD in the National Health and Nutrition Examination Survey, the National Health Interview Study and the Behavioral Risk Factor Surveillance Survey that asks about COPD by name. (Page 78)

Action taken or to be taken

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

CDC's NHANES will add special lung function tests (spirometry) beginning in 2007, re-instituting a test conducted on NHANES participants from 1988-94. Two additional features to the lung function testing will be included for the first time in the 2007 NHANES. First, individuals that have evidence of obstructive airway disease on the initial spirometry measurement will have a bronchodilator administered and then a second spirometry performed to assess the prevalence of reversible airway obstruction. Second, a measurement of exhaled nitric oxide will be obtained. This is an easily and rapidly obtained noninvasive test that is a potential surrogate for measuring airways inflammation. This expanded data collection will help improve the completeness of COPD data, and will also allow analysis of change from the previous measure.

Item

**[Diabetes and obesity health promotion]** – The Committee is concerned about the adverse health toll that the twin epidemics of diabetes and obesity are taking across the Nation. An informed and culturally sensitive response is urgently needed to address this escalating epidemic. The Committee encourages CDC to fund projects of national and community organizations that have the capacity to carry out coordinated health promotion programs that will focus on diabetes and obesity in the general population and across minority communities. The Committee further encourages CDC to identify potential grantee organizations directed by and serving individuals from communities with disproportionate diabetes and obesity rates. (Page 79)

Action taken or to be taken

CDC shares the Committee's concern about the obesity and diabetes epidemics. The rapid increase in obesity prevalence rates over the past 20 years foreshadows likely increases in diabetes prevalence rates. The nation's ability to effectively prevent and control diabetes hinges, in great measure, on our ability to effectively prevent and control obesity and body weight issues.

In May 2006, CDC held the first national co-sponsored Obesity and Diabetes Conference. More than 1,000 participants explored science, policy, education, program planning, implementation, and evaluation to prevent and control diabetes and obesity. The event highlighted successful, cost-effective public and private programs on diabetes and obesity, as well as innovative awareness-raising strategies. The conference also provided opportunities for skill building, information sharing, and networking.

CDC's REACH Program - Racial and Ethnic Approaches to Community Health – funds communities to develop and implement innovative, community-based approaches to addressing racial and ethnic health disparities, particularly in the inter-related chronic disease areas of diabetes, heart disease, and related risk factors. Strategies developed and implemented are based in the unique historical and cultural experiences of racial and ethnic minority communities. REACH is demonstrating dramatic results.

For example, in South Carolina, the REACH 2010 Charleston and Georgetown Diabetes Coalition reports that a 21 percent gap in blood sugar testing between African Americans and whites has been virtually eliminated. More African Americans are having the recommended annual tests for lipid profile and kidney function, and are increasingly being referred for eye exams and blood pressure checkups than when the program began. Lower-extremity amputations in African American diabetic patients have dramatically decreased. In Charleston County, amputations fell by almost 36 percent, from 31 percent in 1999 to less than 20 percent in 2002; in Georgetown County, the percentage decreased by almost half, from 44 percent in 1999 to 24 percent in 2002.

REACH communities will enter into a new 5-year funding cycle in FY 2007. A spring 2007 competition for REACH presents an important opportunity for community organizations that have the capacity to carry out coordinated health promotion programs in chronic disease areas such as diabetes and related risk factors to apply. Historically, most

organizations applying have been organizations directed by and serving individuals from communities that bear a disproportionate health burden issues, particularly the inter-related chronic disease issues of heart disease, diabetes, and related risk factors.

During this next cycle of REACH, there will be an increased focus on dissemination. The most effective strategies emerging from REACH will be disseminated to other health programs so that they can be adopted widely. Lessons learned about how to work effectively in diverse communities can inform health-improvement efforts across our nation and increase the impact of health programs in reducing health disparities.

The National Diabetes Education Program, a jointly sponsored CDC/NIH initiative that involves public and private partners to improve the treatment and outcomes for people with diabetes, promote early diagnosis, and prevent the onset of diabetes, funds eight national organizations to address diabetes prevention and control in populations at high risk. These organizations (American Association of Indian Physicians, Black Women's Health Imperative, Khmer Health Advocates, National Alliance of Hispanic Health, National Association of School Nurses, National Latina Health Network, National Medical Association, and Papa Ola Lokahi) are competitively funded under the National Program to Promote Diabetes Education Strategies in Minority Communities. Activities increase awareness and education about diabetes, build coalitions and partnerships, disseminate best practices and proven interventions, and promote NDEP messages using culturally effective community-based approaches.

Additionally, Steps to a HealthierUS is acting as a catalyst to make needed changes in local communities related to physical inactivity, poor nutrition, and smoking to combat the rising rates of obesity, diabetes, and asthma among adults and youth. Successes and models from Steps can be replicated by other communities, for local action. Special focus is directed toward populations with disproportionate burden of disease and preventive services. Successes include enhancements related to nutrition and physical activity, such as mandated physical education and increased offerings of fruits and vegetables in Steps communities.

Item

**Diabetes** – The high incidence of diabetes among Native American, Native Alaskan, and Native Hawaiian populations persists. The Committee is pleased with the CDC's efforts to target this population, in particular, to assist the leadership of Native Hawaiian and Pacific Basin Islander communities. It is important to incorporate traditional healing concepts and to develop partnerships with community health centers. The Committee encourages CDC to build on all its historical efforts in this regard. (Page 79)

Action taken or to be taken

Papa Ola Lokahi (POL), a non-profit organization concerned with the health and wellness of Native Hawaiians and Pacific Islanders, and the Association of American Indian Physicians (AAIP) are among the eight national minority organizations funded by CDC to address diabetes prevention and control in high risk populations. The POL Pacific Diabetes Education Program works in partnership with consumers of diabetes care services, health care providers, local diabetes programs and the Diabetes Prevention and Control Programs in Hawaii and the US affiliated Pacific Island jurisdictions to address the need for culturally and linguistically appropriate diabetes education materials. The AAIP is working with national and regional organizations to increase their ability to develop and implement community-based interventions, and to assist health care providers in providing culturally appropriate diabetes education and support to AI/AN communities.

In addition, state-based Diabetes Prevention and Control programs with large Native American, Native Alaskan, and Native Hawaiian populations work with organizations in their state to address the diabetes education and diabetes care concerns of these communities.

Item

**Diabetic Kidney Disease** – The Committee strongly encourages the CDC to work closely with the National Institute of Diabetes, Digestive and Kidney Diseases to ensure that the biosamples and data from the Genetics of Kidneys in Diabetes collection are made available to the research community in a timely and efficient manner. (Page 79)

Action taken or to be taken

CDC strongly supports the distribution of data and samples from the Genetics of Kidneys in Diabetes (GoKinD) collection. CDC has met all requests that have been approved by the GoKinD Executive Committee administered by the National Institutes of Diabetes, and Digestive, and Kidney Diseases. CDC has requested a plan from the co-owner of the collection, the Juvenile Diabetes Research Foundation (JDRF), for future distribution with the ethical consent obtained from participants by JDRF.

Item

**Food Allergy and Anaphylaxis Information** – . . . . The Committee encourages CDC to create a CDC Center that will provide guidance to the public and health care professionals about how to avoid products with allergy-causing ingredients and how to respond to potentially life-threatening reactions to food allergens. The Committee encourages CDC to partner with a national nonprofit organization with a proven track record in developing and providing general information, educational materials, and training support to the public, health care providers, educators, Government agencies and food and restaurant industry leaders regarding the primary and secondary prevention of allergic reactions to food. (Page 80)

Action taken or to be taken

CDC utilizes the expertise and resources of the Food Allergy and Anaphylaxis Network (FAAN) to develop and provide information and materials to schools across the U.S. With adequate funding, CDC would explore the creation of a specific Center to address guidance for the public on food allergens.

CDC has also worked with FAAN to incorporate guidance on food allergies into the Food-Safe Schools Action Guide currently available at [www.foodsafeschools.org](http://www.foodsafeschools.org).

CDC is working with the National School Boards Association (NSBA) to develop guidance on food-borne illness and food allergies to school boards and administrators.

In addition in Fall 2007, CDC will place new guidance for schools on food allergies at [www.cdc.gov/healthyyouth](http://www.cdc.gov/healthyyouth), which will provide basic information for schools and will reference the FAAN guidelines.

Item

**Liver Wellness** – The Committee continues to be concerned about the prevalence of hepatitis and encourages CDC, particularly the Division of Adolescent and School Health, to work with voluntary health organizations to promote liver wellness with increased attention toward childhood education and prevention. (Page 81)

Action taken or to be taken

CDC's Coordinated School Health Program, within the Division of Adolescent and School Health, provides a model for organizing health programs within schools to maintain and promote the well-being of young people, including liver wellness. CDC funds education and health agencies to help schools prevent sexual risk behaviors that result in HIV infection, especially among youth who are at highest risk. Since several strains of hepatitis are spread through sexual contact, prevention of sexual risk behaviors supports the goal of decreasing the prevalence of hepatitis.

Item

**Lung Disease** – The Committee encourages the CDC to consider supporting efforts to validate the importance of spirometry screenings in early detection of lung disease. Such efforts include further research and development of projects to facilitate the translation of new scientific knowledge into spirometry public health screening programs. The Committee urges the CDC to continue to coordinate with the National Heart, Lung, and Blood Institute in translating the results of these efforts into guidance for public health programs, including vital signs and screening programs. (Page 81)

Action taken or to be taken

CDC is a member of the National Heart, Lung and Blood Institute's National Asthma Education and Prevention Program (NHLBI) and continues to work with NHLBI specifically related to asthma. In addition, CDC's National Asthma Control Program has funded Dr. James Stout, University of Washington, to develop a training CD on spirometry. The goal of this CD is to train providers how to administer, interpret, and ensure the quality of pulmonary function testing in their office. The first version of the CD to train primary care providers in the proper technique and interpretation of spirometry has been completed. It is currently being used by CDC's Controlling Asthma in American Cities grantees on a pilot basis. Several studies (that are not funded by CDC) are currently in progress to assess whether training primary care providers in the use of spirometry improves the quality of care provided to patients with asthma. CDC is awaiting results of these studies before disseminating the CD further.

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

CDC's NHANES will add special lung function tests (spirometry) beginning in 2007, re-instituting a test conducted on NHANES participants from 1988-94. Two additional features to the lung function testing will be included for the first time in the 2007 NHANES. First, individuals that have evidence of obstructive airway disease on the initial spirometry measurement will have a bronchodilator administered and then a second spirometry performed to assess the prevalence of reversible airway obstruction. Second, a measurement of exhaled nitric oxide will be obtained. This is an easily and rapidly obtained noninvasive test that is a potential surrogate for measuring airways inflammation. This expanded data collection will help improve the completeness of COPD data, and will also allow analysis of change from the previous measure.

Item

**Lupus** – The Committee recognizes that lupus is a serious, complex, debilitating chronic autoimmune disease that can cause inflammation and tissue damage to virtually any organ system in the body and impacts between 1.5 and 2 million individuals. The Committee is concerned by the lack of reliable epidemiological data on the incidence and prevalence of all forms of lupus among various ethnic and racial groups. The Committee has included sufficient resources to continue CDC's lupus-related activities. (Page 81)

Action taken or to be taken

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

Since lupus is difficult to diagnose, its broad spectrum of severity and corresponding burden on society has been extremely difficult to estimate. There is consensus that science needs to be improved in this area. CDC's registry is a first major step forward in improving this science. CDC initiated two carefully designed, focused, population-based lupus registries in Michigan and Georgia. The projects are in the fourth year of study. This investment will give CDC important information about lupus with national implications. In addition, the registries are a ready-made platform for additional studies that will provide both public health and clinical communities with information to start to alleviate the suffering that lupus causes.

Item

**Nutrition, Physical Activity, and Obesity** – The Committee understands that the multiple factors contributing to the overweight and obesity epidemic took years to develop. Reversing the epidemic will require a long-term, well-coordinated, concerted approach to reach Americans where they live, work, play, and pray. Effective collaboration among the public, voluntary, and private sectors is critical to reshape the social and physical environment of our Nation's communities and provide the necessary support, information, tools, and realistic strategies needed to reverse the current obesity trends nationwide. Given the large, preventable health and economic burden of poor nutrition, physical inactivity, and unhealthy body weight, the Committee encourages CDC to continue its leadership role in developing, implementing, and evaluating nutrition and physical activity population-based strategies to prevent and control overweight and obesity. Targeting prevention efforts throughout the lifespan – including children as young as toddlers--as well as promoting fruit and vegetable consumption through CDC's Federal lead role in the national 5 A Day program, and increasing the proportion of children, adolescents, and adults who meet daily physical activity recommendations should remain priorities for the agency. The Committee has provided \$500,000 above the fiscal year 2006 level to sustain and expand CDC's support of the 5 A Day Program. To reduce consumer confusion about the myriad of health messages about obesity, diabetes, and cardiovascular disease, the Committee encourages the CDC to design and develop mechanisms for fast-tracked translation of research into reasoned guidance for the American public. (Page 82)

Action taken or to be taken

In FY 2006, CDC continued efforts in developing, implementing, and evaluating population-based strategies to prevent and control overweight and obesity, as well as to enhance health and wellness. CDC funds 28 state health programs to improve nutrition and physical activity among target groups, as well as prevent and control obesity and other chronic diseases. State programs conduct nutrition and physical activity interventions through population-based strategies, such as policy-level change, environmental change, and social marketing.

CDC also published the Weight Management Research to Practice Series (R2P), which summarizes the science on weight management topics for health professionals and the general public. An overview of the science is compiled into a summary document appropriate for public health professionals, including implications for practice. In addition, some installments in the series are accompanied by a tool geared toward a lay audience. These companion brochures are designed for practitioners to use with their clients and patients to explain the concepts correctly and

provide practical tips on implementing strategies to help manage weight. There are three R2Ps currently available on the CDC website.

In FY 2007, CDC will work with the Robert Wood Johnson Foundation (RWJF), the Kellogg Foundation, and Kaiser Permanente to improve the evidence base and our ability to provide consistent evaluation of the most promising strategies for the prevention and control of obesity. Shared evaluation approaches and assessment indicators across funding agencies and programs will facilitate program assessment and refinement. Two projects are under consideration, Community Environmental and Policy Indicators Project for Obesity Prevention and Control and Early Assessments of Environmental Interventions. The first includes two phases, one for identifying and selecting potential indicators and performance measures for the evaluation of obesity prevention programs and interventions, and the second for developing measurement and assessment protocol for indicators, and implementing and testing in various setting of selected indicators.

The second initiative, originated by RWJF, proposes collaboration with CDC to identify interventions that are most promising and ready-for-evaluation. The early assessment process will be structured to rapidly and objectively evaluate natural experiments and promising practices to assess the initial impact and applicability to other communities. Projects and models deemed most promising could be targeted for more in depth evaluation.

CDC continued to provide national leadership in the promotion of fruit and vegetable consumption in the United States. In FY 2006, CDC assumed federal leadership for the 5 A Day for Better Health partnership from NCI.

In FY 2007, CDC will launch a new brand for the current 5 A Day for Better Health partnership to reflect the latest scientific evidence for fruit and vegetable consumption. As the lead health authority for the new brand, CDC developed the nutrition standards that licensees must adhere to if used on products or recipes. CDC also organized a Government Oversight Committee to ensure scientific integrity of the brand and that all messages and products reflect the latest science. The Government Oversight Committee is made up of representatives of CDC, NIH, FDA, USDA, the California Department of Health, and the National Council of Fruit and Vegetable Nutrition Coordinators. CDC is working with other partners to strengthen the governance and reach of the partnership.

CDC continues to support efforts to promote fruit and vegetable consumption by developing and providing evaluation tools and communication resources to state and local entities. Communication resources partners include resources and tip sheets for working with worksites, school nutrition services, and special populations (e.g., Asians and Pacific Islanders, low-income Hispanic mothers, African American churches, and seniors). At the national level, CDC is working with USDA to provide resources, technical assistance, and training to sixteen states supporting free fruit and vegetable snacks in schools through the Fruit and Vegetable Pilot Program.

Item

**Nutrition and Physical Activity Study** – Within the amount provided for Nutrition, Physical Activity and Obesity, the Committee has provided sufficient funds to conduct a study of the impact of school nutrition and physical activity programs on academic outcomes, including school attendance, student behavior, and student achievement on standardized tests. (Page 82)

Action taken or to be taken

There is a growing body of research regarding the impact of school health programs and improved academic performance. A number of studies have found positive outcomes associated with physical activity and school breakfast programs on academic performance. Schools are in a uniquely favorable position to improve nutritional status and increase physical activity and fitness among their students. A systematic study to evaluate the impact of school nutrition and physical activity programs is needed. Results from this study could highlight options for school health program guidelines and policies to improve academic outcomes, school attendance, student classroom behavior, and achievement on standardized tests.

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 sufficient funding to States to maintain their capacities to assess the prevalence of oral diseases, to target interventions, such as additional water fluoridation and school-linked sealant programs, and resources to the underserved, and to evaluate changes in policies, programs, and disease burden. The Committee encourages the CDC to advance efforts to reduce the disparities and health burden from oral cancers that are closely linked to chronic diseases such as diabetes and heart disease. (Page 83)

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, support 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 Fibrosis** – The Committee previously has expressed concern regarding the need to expand public health strategies to combat lung disease particularly pulmonary fibrosis, a disease that is terminal and for which there is currently no effective treatment. Many individuals are diagnosed too late to initiate treatment regimens that could reduce morbidity and mortality. Currently more than 40,000 die from this disease annually. Lung disease is the third leading cause of death in the United States. The Committee encourages the CDC to collaborate with the National Heart, Lung, and Blood Institute to develop surveillance, epidemiology, and health outcomes programs. (Page 84)

Action taken or to be taken

CDC is a member of the National Heart, Lung and Blood Institute's National Asthma Education and Prevention Program (NHLBI) and continues to work with NHLBI specifically related to asthma. In addition, CDC's National Asthma Control Program has funded Dr. James Stout, University of Washington, to develop a training CD on spirometry. The goal of this CD is to train providers how to administer, interpret, and ensure the quality of pulmonary function testing in their office. The first version of the CD to train primary care providers in the proper technique and interpretation of spirometry has been completed. It is currently being used by CDC's Controlling Asthma in American Cities grantees on a pilot basis. Several studies (that are not funded by CDC) are currently in progress to assess whether training primary care providers in the use of spirometry improves the quality of care provided to patients with asthma. CDC is awaiting results of these studies before disseminating the CD further.

Item

**REACH Initiative** – The Committee recognizes the strengths that national/multi-geographical minority organizations may be able to provide to the REACH Initiative. Such organizations could have the capacity to influence communities through pre-existing coalitions and collaborative relationships. Such organizations may also be able to provide key support to local organizations that may lack the infrastructure needed to fully implement the programmatic activities required for this important program. The Committee urges CDC to include such organizations among the entities that are eligible to compete for funding without preventing other applicants from receiving these grants. The Committee has provided sufficient resources to continue REACH activities at the fiscal year 2006 level. (Page 84)

Action taken or to be taken

In FY 2007, CDC's REACH program will begin a new five-year funding cycle. There will be an increased focus on dissemination of lessons learned from REACH. Many of the newly funded projects will have a regional/national focus, which will extend the impact of REACH. In addition to the program's ongoing partnerships with several agencies and offices within the U.S. Department of Health and Human Services, governments, businesses, faith-based organizations, communities, and national foundations, CDC has identified the need to expand REACH to include national/multi geographical minority organizations. Eligibility criteria will allow new REACH communities to partner with national/multi geographical minority organizations, which can play a vital role in CDC's health promotion and dissemination efforts.

Item

**Steps to a Healthier United States** – The Committee applauds the Department's continued commitment to tackling the problems of obesity, diabetes, and asthma. The Committee agrees that these are three of the most critical chronic conditions afflicting Americans. The Committee is concerned that existing programs that address these problems have not yet been implemented in all of the States. The Committee has provided sufficient resources to continue this initiative and existing programs within CDC that are aimed at obesity, diabetes, and asthma. The Committee strongly urges CDC to coordinate the efforts of these programs such that the best possible outcome is achieved using these limited funds. (Page 84/85)

Action taken or to be taken

Through the Steps program, local communities are empowered to implement evidence-based interventions in their communities, schools, workplaces, and health care settings that will make a positive difference in the environment, access to care, and policies related to the focus areas and risk factors. Successes include the adoption of clean

indoor air ordinances, enhancements related to nutrition and physical activity, mandated physical education, and increased offerings of fruits and vegetables. This concentration of action in vanguard communities will accelerate state and national efforts. Models created can be replicated at the community level by state health department programs and by local communities (through local resources or other sources.)

Much of the community-level work of the Steps Program is being accomplished through state health departments, and the Steps Program builds on the strengths and infrastructure of existing chronic disease prevention and health promotion efforts. Over half of Steps communities are funded through state health departments, which provide technical assistance related to programmatic and evaluation activities. Steps programs in these communities utilize the resources and infrastructure of their state health departments to implement action plans developed at the state level to address diabetes, obesity, and asthma. In addition, all Steps communities are required to coordinate their local activities with the efforts already funded and underway statewide.

Steps communities are making major contributions to our knowledge of what works to improve the health of people and communities at the local level. These experiences are shared not only within the funded Steps community, but throughout the state in which the Steps community resides. The urgency for immediate action and immediate models for local-level change require concentrated efforts in a set of vanguard communities to show what can be done at the local level.

Item

**Sudden Infant Death Syndrome** – To prevent Sudden Infant Death Syndrome [SIDS], the Committee encourages CDC to consider supporting a National Campaign for Cribs pilot program in partnership with a national voluntary organization dedicated to infant survival. Such a pilot project may be composed of a public health education component for new parents and caregivers and seek to provide a crib for babies whose mothers and caregivers cannot afford a proper sleeping environment for their children. (Page 85)

Action taken or to be taken

CDC is pleased that strong organizations are assisting mothers and caregivers with education and assistance concerning proper infant sleeping environments. Currently CDC offers public health education training classes to law enforcement and coroner offices around the country for properly identifying Sudden Infant Death Syndrome (SIDS) deaths. In FY 2007, CDC will conduct five regional train-the-trainer academies for investigators and death certifiers to consistently collect data at the death scene and accurately report findings on the death certificate.

CDC is also working on identifying the risk factors for SIDS. CDC is conducting a pilot surveillance system on Sudden Unexplained Deaths in Infants (SUIDI) designed to collect information regarding the circumstances leading to infant death. The SUIDI pilot will be evaluated in 2007. It may be possible after the SUIDI pilot evaluation to develop appropriate public health education messages beyond the SUIDI training classes.

Item

**Centers for Birth Defects Research and Prevention** – The Committee encourages CDC to consider expanding the promising research being conducted by the regional Centers for Birth Defects Research and Prevention and maintain assistance to States to implement and expand community - based birth defects tracking systems, programs to prevent birth defects, and activities to improve access to health services for children with birth defects. (Page 85)

Action taken or to be taken

CDC continues to work closely with grantees and funded partners to advance its birth defects tracking, research and prevention activities. The CDC-funded Centers for Birth Defects Research and Prevention rely on pooled data from state tracking programs to conduct the largest study of the causes of birth defects ever conducted, the National Birth Defects Prevention Study. The research agenda for 2006 through 2008 for this study was completed this year, and studies on several key exposures are in press.

Item

**Craniofacial Malformation** – The Committee has continued funding for CDC's initiatives to help families of children with craniofacial malformations. The Committee commends CDC for their work on this important public health issue and encourages them to continue work with State and private partners, including the National Foundation for Facial Reconstruction. (Page 86)

Action taken or to be taken

CDC continues to work closely with grantees, including the National Foundation for Facial Reconstruction, to advance critical public health work on craniofacial malformations. In 2006, CDC worked with experts to develop a public health research agenda for two important types of craniofacial malformations, orofacial clefts and craniosynostosis, which will help guide important public health work in this area.

Item

**Fetal Alcohol Spectrum Disorders** – The Committee is concerned by the prevalence of fetal alcohol spectrum disorders [FASD] in the United States and notes that drinking during pregnancy is the Nation's leading known preventable cause of mental retardation and birth defects. To publicize and promote awareness of this critical updated public health information, the Committee has provided sufficient resources to continue these activities. (Page 86)

Action taken or to be taken

CDC shares the Committee's concern regarding the prevalence and public health impact of fetal alcohol spectrum disorders in the United States and continues efforts to promote awareness and prevention strategies. CDC recently published a study on a successful intervention to reduce alcohol-exposed pregnancies. The study found that motivational counseling provided to high-risk women prior to pregnancy can help reduce their risk by two fold. In addition, CDC collaborated with the American College of Obstetricians and Gynecologists to develop a toolkit for providers, "Drinking and Reproductive Health: A Fetal Alcohol Spectrum Disorders Prevention Toolkit." The toolkit contains information on screening, education, and counseling, and is designed to help women's healthcare clinicians identify and intervene when they encounter risky drinking in childbearing aged women, regardless of pregnancy status.

Item

**Fragile X** – The Committee is encouraged by the CDC's efforts related to Fragile X and support for the Fragile X public health program to expand surveillance and epidemiological research of Fragile X. Given the limited resources available, the Committee urges the CDC to ensure that the agency's educational and awareness activities under this initiative are not duplicative of current efforts of nationally recognized authorities in the area of Fragile X, but are instead focused on supporting the further dissemination and distribution of existing informational materials. The Committee is aware that the introduction of an early childhood developmental screening program, creation of appropriate genetic counseling protocols for supporting families of new diagnoses, and the development of standards of care for clinicians and care providers are all existing agency priorities that would directly benefit individuals impacted by Fragile X and related conditions. The Committee encourages the CDC to consider Fragile X as a model for these important initiatives. (Page 86/87)

Action taken or to be taken

CDC agrees that efforts related to Fragile X (FX) awareness should be effectively coordinated with FX voluntary groups. The agency continues productive collaborations with nationally recognized authorities on FX, including the National Fragile X Foundation, to disseminate information to healthcare providers and the general public. For example, expanded FX guidelines were recently developed through focused advisory meetings of authorities on FX. These guidelines are currently being disseminated through publication in various peer-reviewed journals, postcard mailings to healthcare providers in specific medical disciplines (i.e. neurology, psychiatry, obstetrics/gynecology), and presentations at conferences held by professional medical societies.

Item

**Marfan Syndrome** – The Committee continues to be interested in Marfan syndrome, a progressive and degenerative genetic disorder which can result in sudden loss of life from aortic aneurysms. Unfortunately, many individuals affected by Marfan syndrome are undiagnosed or misdiagnosed until they experience a cardiac complication. Increasing awareness of this life-threatening disease is vital to ensuring accurate diagnosis and appropriate disease management in patients who are at risk for cardiovascular complications. The Committee encourages CDC to partner with the Marfan syndrome community to increase awareness of the disease among the general public and health care providers. (Page 87)

Action taken or to be taken

CDC is aware of the public health concerns regarding Marfan syndrome and shares the Committee's concerns. CDC is not actively involved in efforts related to Marfan syndrome but agrees that partnering with the community could increase awareness of the disease among the general public and health care providers.

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 87)

Action taken or to be taken

CDC shares the Committee's concern regarding Prader-Willi syndrome. CDC is not actively involved in efforts related to Prader-Willi syndrome but agrees that partnering with voluntary organizations to develop and disseminate educational material could advance work in this area.

Item

**Eating Disorders** - The Committee is concerned about the growing incidence and health consequences of eating disorders among the population. The extent of the problem while estimated by several long-term outcome studies as being high remains unknown. The Committee urges the CDC to research the incidence and morbidity and mortality rates of eating disorders, including anorexia nervosa, bulimia nervosa, binge eating disorder, and eating disorders not otherwise specified across age, race, and sex. (Page 89)

Action taken or to be taken

A variety of statistical surveys and systems operated by CDC contribute to our basic understanding of eating behaviors and disorders. Since 1999, the National Health and Nutrition Examination Survey (NHANES) has included questions on the weight history (attempts to lose weight and methods used to try to lose weight) of participants ages 16 and above. In addition, for 2000 to 2004, NHANES included assessments of eating disorders for youths 8-19 years of age using the computerized version of the National Institute for Mental Health Diagnostic Interview Schedule for Children (DISC). The module from DISC includes a series of questions related to eating, weight, and related behaviors. These data are available for analysis by researchers in the Research Data Center at the National Center for Health Statistics. For 2005-2008, NHANES includes questions targeted to youth 8 - 15 years of age about their perceptions of their weight and behaviors they have taken to lose weight.

In addition to data gathered through NHANES, coding systems for both mortality and morbidity data include categories for various eating disorders. National mortality data, including cause of death, are produced from death certificates and are captured in the National Vital Statistics System. Health care data, including some types of morbidity associated with eating disorders, are obtained from national surveys of providers and provide information on patients, diagnoses, and treatments in various settings. These data are captured in the National Health Care Survey. Data from these systems are released on public use files for analysis by researchers.

Finally, two additional surveys gather information to assess prevalence among youth and efforts to address eating disorders in schools. The national biennial Youth Risk Behavior Survey (YRBS) monitors priority health risk behaviors, such as unhealthy eating behaviors, that contribute to the leading causes of death, disability, and social problems in the United States. YRBS includes questions that inquire about the use of diet pills, laxatives, or denying oneself food in order to control or lose weight. The School Health Policies and Programs Study (SHPPS) is a national survey periodically conducted to assess school health policies and programs at the state, district, school, and classroom levels. SHPPS includes questions to ascertain whether schools provide eating disorder education, prevention and treatment services.

Item

**Psoriasis** - The Committee urges the NCHS to ensure that any data collected on psoriasis be comprehensive and include the full age range of individuals affected by the disease including children, adolescents and adults. The Committee is interested in having the Center collect and report psoriasis incidence and prevalence data that are based on nationwide epidemiological studies. If such data are not currently available, the Committee encourages the Center to undertake a comprehensive epidemiological study with a focus on determining incidence of psoriasis and psoriatic arthritis. The Committee urges CDC to consider working with a national psoriasis organization to develop a surveillance program to ascertain and monitor psoriasis and psoriatic arthritis incidence and co-morbidities. (Page 89)

Action taken or to be taken

The National Health and Nutrition Examination Survey (NHANES) has collected data on psoriasis since 2003. Three questions about psoriasis, developed with input from the National Psoriasis Foundation, have been asked of survey participants ages 20 - 59. These questions ask whether the participant has ever been told by a health professional that he/she had psoriasis, how much of a problem the psoriasis has been in daily life, and how extensive the psoriasis is. These data provide estimates of psoriasis and severity for the United States population ages 20 - 59. This data collection was planned and funded in collaboration with NIH's National Institute of Arthritis and Musculoskeletal and Skin Diseases and continued through 2006. A preliminary estimate of prevalence from the 2003-2004 sample shows that the prevalence is relatively low in the population.

- The crude overall prevalence for adults ages 20-59 is 3.14 percent.
- For non-hispanic white women ages 20-59, the prevalence is 3.45 percent.
- For non-hispanic white men ages 20-59, the prevalence is 4.06 percent.

Currently CDC does not have data on psoriatic arthritis. Although some CDC surveys obtain data on arthritis, the surveys do not ask specifically about psoriatic arthritis. These surveys are conducted on small samples of the population, making it difficult to capture reliable information on health conditions, such as psoriatic arthritis, that occur relatively infrequently in the population.

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 encourages CDC to continue 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. (Page 90)

Action taken or to be taken

CDC's asthma control program is further expanding its outreach aimed at increasing public awareness of asthma control and prevention strategies, particularly among at-risk populations in underserved communities. This year, through its National Asthma Health Education Enhancement effort, CDC has funded voluntary health organizations such as the Allergy and Asthma Network/Mothers of Asthmatics, American Lung Association (ALA), and Asthma and Allergy Foundation of America to conduct activities related to asthma education. These activities range from identifying effective educational programs for adults that can be adapted for nationwide use to educating children with asthma and their families and caregivers. CDC created a Web site called "Effective Interventions for Asthma Control" for state and local public health organizations and other partners to assist in efforts to determine what has been evaluated and best practices. This website provides access to interventions and other materials for partners to adapt and implement related to controlling and managing asthma.

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

CDC is also currently funding two national nongovernmental organizations (ALA and American Association of School Administrators) to provide capacity building assistance to faith-based institutions, youth service providers, or parent organizations interested in addressing asthma in schools. Activities include funding community-based approaches to comprehensive asthma management in schools, highlighting promising practices, and providing opportunities for state-level collaboration to support leadership and expertise around childhood asthma.

All of CDC's partners funded for school health activities use CDC's research-based document, "Strategies for Addressing Asthma Within a Coordinated School Health Program," released in Fall 2002, to guide their programs. CDC's new version of its popular "School Health Index: A Self-Assessment and Planning Guide" includes asthma information and provides helpful guidance to funded partners on ways to use research-based strategies to address asthma in schools. Also, CDC's newly updated "Resources for Addressing Asthma in Schools" highlights several publications and websites developed by national organizations, including the Center for Health Care Strategies, RAND Corporation, the American Academy of Pediatrics, and the American Academy of Allergy, Asthma, and Immunology.

Item

**Biomonitoring** – The Committee applauds the CDC's biomonitoring efforts and encourages the agency to continue this program and continue to improve its efforts to communicate these results in context. In particular, the CDC's National Report on Human Exposure to Environmental Chemicals is a significant new exposure tool that provides valuable information for setting research priorities and for tracking trends in human exposures over time. Accordingly, the Committee continues to support the CDC environmental health laboratory's efforts to provide exposure information about environmental chemicals. As CDC has recognized, this information does not by itself suggest harmful effects in humans. The Committee understands that for many chemicals it is difficult to interpret biomonitoring information in a health risk context. The Committee encourages the CDC to collaborate with Federal Government and private sector toxicologists, health scientists and laboratory analytical chemists, to facilitate the development of the necessary methods to interpret human biomonitoring concentrations in the context of potential health risks. (Page 90/91)

Action taken or to be taken

Currently, CDC is works with 50 partners , including federal agencies (e.g., EPA); state health departments (e.g., California, New York, New Jersey, Nevada, Arizona, New Hampshire, New Mexico) academic institutions (e.g., Harvard School of Public Health, Columbia University, Mt. Sinai Medical Center, the University of California at Berkeley, the University of Missouri at Columbia, University of Iowa and the University of Wisconsin at Milwaukee) and private -sector groups on human exposure studies that attempt to determine whether an association exists between people's exposure to a particular chemical and an adverse health effect. In FY 06, CDC conducted 52 such studies, including studies of human exposure to heavy metals (e.g., mercury), pesticides, personal-care products, and volatile organic compounds. Results of these studies contribute to the growing body of knowledge about people's exposure to environmental chemicals. In addition, CDC's Environmental Health Laboratory will release its Fourth National Report on Human Exposure to Environmental Chemicals in 2007; the Report will contain exposure data by age, sex, and race/ethnicity on at least 250 environmental chemicals found in the general U.S. population.

Item

**Volcanic Emissions** – The Committee remains concerned about the public health issue of volcanic emissions. Such emissions contribute to the exacerbation of a myriad of pre-existing health conditions in many island residents, especially children. The acute- and long-term impact that these emissions have on both the healthy and pre-disposed residents warrants further study. The Committee encourages the establishment of a dedicated center that embraces a multi-disciplinary approach in studying the short- and long-term health effects of the volcanic emissions. (Page 91/92)

Action taken or to be taken

Since 1998, CDC's National Asthma Control Program has been funding the Hawaii State Department of Health (HDOH) to address the problem of asthma among medically-underserved populations in the state. The NACP is funding the HDOH to explore the effects of volcanic air pollution ("vog") on cardiopulmonary health with community researchers, volcanologists, environmental health scientists, and HDOH staff on the Big Island of Hawaii for the "Volcanic Emissions and Airway Function, Inflammation, Heart Rhythm (AIR)" project. Community researchers will work with Hawaii Department of Health staff and volcanologists by engaging residents of the Big Island to explore the hypothesis that adults who inhale volcano-derived particulate matter, sulfur dioxide, or acid aerosols are at greater risk of cardiopulmonary effects. The objectives of the project are to: (1) build capacity in the community to address environmental research questions, (2) monitor concentrations of particulate matter, acid aerosols, and sulfur dioxide in Volcano Village and Pahala, Hawaii, (3) test the feasibility of measuring airway function, inflammation, and autonomic heart rate variability in at least 20 residents of Volcano Village, Pahala, and Kona, and (4) plan future investigation of these health effects in at-risk residents of Volcano Village, Pahala, and Kona, compared to the well- characterized Multi-Ethnic Health Research cohort in Kohala, a vog-free community.

Item

**Injury Data** – The Committee commends CDC for participating in discussions among the Home Safety Council, representatives of various injury prevention research groups, and providers of injury data from diverse hazard disciplines. The Committee understands that these discussions addressed the challenges of completeness, quality and consistency of existing injury data collection systems for home safety, traffic, consumer products, and violence. The Committee encourages CDC to continue its participation in this on-going dialog. (Page 92)

Action taken or to be taken

CDC works closely with federal agencies, state and local health departments, non-profit organizations and research institutions. The Home Safety Council is a non-profit, nongovernmental service organization dedicated primarily to the prevention of home related injuries. CDC and Home Safety Council share complementary interests regarding the promotion of injury prevention and control, and the improvement of health and safety in the home and elsewhere.

CDC continues to support the collection and analysis of data to monitor trends and to evaluate programs and is actively engaged in ways to improve the completeness, quality, consistency and existing injury data. CDC funded surveillance systems such as the National Violent Death Reporting System (NVDRS), the National Electronic Injury Surveillance System (NIESS) and the Traumatic Brain Injury Surveillance System, support this crucial collection of needed data. NVDRS, which is currently functional in 17 states, provides a timelier and more complete picture of circumstances surrounding violent deaths than previously available. The NIESS system is a surveillance system of a nationally representative sample of US hospitals which details emergency department (ED) visits, injury mortality, and leading cause of death statistics. CDC works collaboratively with the United States Consumer Products Safety Commission to maintain the NIESS system. The Traumatic Brain Injury Surveillance system is funded by CDC in 30 states to conduct basic traumatic brain injury (TBI) and other injury surveillance through the Integrated Core Injury Prevention and Control Program.

CDC will continue to explore ways to improve data on injury and violence-related circumstances, especially place of occurrence, in federal and state-based data collection systems to facilitate the availability of high quality data for use in monitoring injuries that occur in the home and other places. CDC will continue to explore avenues of partnership with the Home Safety Council and other organizations in the area of injury prevention and control.

Item

**National Violent Death Reporting System** – The Committee is supportive of the National Violent Death Reporting System, which is a State-based system that collects data from medical examiners, coroners, police, crime labs, and death certificates to understand the circumstances surrounding violent deaths. The information can be used to develop, inform, and evaluate violence prevention programs. The Committee urges the CDC to continue to work with private health and education agencies as well as State agencies in the development and implementation of an injury reporting system. (Page 92)

Action taken or to be taken

Established by the CDC in FY 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 linking information from law enforcement agencies, medical examiners and coroners, health providers, crime laboratories and other agencies. As of January 2007, CDC continues to fund 17 states to implement NVDRS. Through the NVDRS, states can quickly see how their problems compare with other states around 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

**Violence Against Women** – The Committee urges CDC to increase research on the psychological sequelae of violence against women and expand research on special populations and their risk for violence including adolescents, older women, ethnic minorities, women with disabilities, and other affected populations. (Page 92)

Action taken or to be taken

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

In addition, CDC supports four sites to conduct efficacy and effectiveness trials of interventions to prevent intimate partner violence and/or its negative consequences for at-risk or underserved populations. Additionally, CDC funds two organizations to integrate prevention principles, concepts and practices into racial and ethnic minority community efforts to address sexual and intimate partner violence.

CDC also developed the Choose Respect initiative to help adolescents form healthy relationships and to prevent dating abuse before it starts. This national effort is designed to motivate adolescents to challenge harmful beliefs

about dating abuse and take steps to form respectful relationships. Choose Respect reaches out to adolescents ages 11 to 14, as they are still forming attitudes and beliefs that will affect how they are treated and how they treat others. The initiative also connects with parents, teachers, youth leaders and other caregivers who influence the lives of young teens.

Item

**Miner's Choice Health Screening Program** – The Committee has provided sufficient resources to continue to implement the Miners' Choice Health Screening Program in fiscal year 2007. This program was initiated to encourage all miners to obtain free and confidential chest x-rays to obtain more data on the prevalence of Coal Workers' Pneumoconiosis in support of development of new respirable coal dust rules. The Committee is strongly supportive of these efforts and urges NIOSH to work to improve this health screening program thereby helping to protect the health and safety of our Nation's miners. (Page 94)

Action taken or to be taken

During FY 2005, the Mine Safety and Health Administration (MSHA) supported the construction of a mobile x-ray and medical examination unit for use in the National Institute for Occupational Safety and Health (NIOSH) Enhanced Coal Workers' Surveillance Program. In FY2005 and FY2006, NIOSH equipped the mobile unit with both traditional film-based and newer digital x-ray equipment, as well as pulmonary function testing equipment. In FY2006 and continuing into FY 2007, NIOSH has been using the mobile examination unit to conduct enhanced coal workers' surveillance by sending the mobile unit to conduct local, convenient examinations in miners' communities. Efforts are being targeted to counties previously identified as being at high risk for progressive coal workers' pneumoconiosis or areas with low participation rates in the mandated Coal Workers' X-Ray Surveillance Program. Over the last year, examinations have been conducted in Utah, western Virginia, and eastern Kentucky. The Enhanced Program has already detected a previously-unrecognized cluster of advanced coal workers' pneumoconiosis in western Virginia which was reported in CDC's Morbidity and Mortality Weekly Report. Over the next year, the Enhanced Program will offer examinations in additional counties prioritized based on disease risk or need to increase participation rates in x-ray Surveillance. In addition, the Enhanced Program will begin to collect both traditional film-based x-rays and digital x-rays as part of an effort to prepare for transition to use of digital x-ray images in Coal Workers' Surveillance.

Item

**National Occupational Research Agenda** – The Committee recommendation includes sufficient resources to maintain funding for CDC's National Occupational Research Agenda (NORA). The Committee believes that NORA is a critical scientific research program, that protects employees and employers from high personal and financial costs of work site health and safety losses. Industries such as agriculture, construction, health care, and mining benefit from the scientific research supported by NORA. The program's research agenda focuses on prevention of disease and injury resulting from infectious diseases, cancer, asthma, hearing loss, musculoskeletal disorders, traumatic injuries, and allergic reactions, among others. The Committee continues to strongly support NORA and encourages expansion of its research program to cover additional causes of workplace health and safety problems. (Page 94)

Action taken or to be taken

CDC continues to support the National Occupational Research Agenda (NORA). NORA has proven to be a critically important scientific program since its inception in 1996 as a partnership effort to define and conduct high priority research. The original vision of NORA specified that the program would return to the stakeholders as the first decade drew to a close to renew its mandate to conduct high priority research based on stakeholder input. That was accomplished in 2006 with more than 1300 separate comments received through the internet and a series of thirteen NORA Town Hall meetings held around the country and attended by more than 1,200 people.

The structure of NORA for its second decade is based on eight industrial sectors assuring consideration of the health and safety needs of all employers and workers and improving the successful movement of research results into workplace practice through partnerships with employers and workers, many of whom are organized by sector. Eight NORA Sector Councils will be established by 2007 with both stakeholder and NIOSH members to draft sector-specific strategic plans for public comment. A NORA Cross-Sector Council will coordinate across sectors when efficiencies can be gained in researching problems and solutions. The eight NORA Sector Strategic Plans will be available in 2008, when implementation will begin.

Based on stakeholder input and initial NORA Sector Council deliberations, future NORA funding of research projects will likely be targeted not only to the previously-recognized diseases and injuries but also to additional priority causes of workplace health and safety problems including such areas as high fatality rates in the oil and gas industry, motor vehicle accidents in the wholesale and retail trade sector, the lack of a safety culture at worksites, and poor understanding of the business case for occupational safety and health.

Item

**[Respirator facemasks]** – The Committee encourages NIOSH to consider the value of a study to evaluate all classes of disposable NIOSH approved respirator facemasks, including but not limited to particulate and antimicrobial technology for effectiveness against transmission of avian influenza and other pathogens.

Action taken or to be taken

CDC has taken a number of actions to address respirator facemasks:

- Expedited N95 approval process of new products. The N95 filtering facepiece (FFR) approval process has been improved, reducing approval times for N95 particulate respirators from over 90 days to an average of 53 days. Five new FFR manufacturers received approvals in 2006.
- Program collaborations among NIOSH respirator certification, FDA and EPA programs for more efficient and expedient evaluation of products with antimicrobial treatments: NIOSH has instituted a policy to not approve antimicrobial claims unless the applicant has FDA and EPA approvals. The EPA approval must be an approval for use in the breathing zone and not an exemption. This directs the manufacturer to the proper agencies for evaluation of the efficacy and safety of any biocide treatments for which they intend to make claims. This utilizes existing programs in the EPA and FDA to assure product safety as well as validity of efficacy claims and ensure respirators making such claims have received all the proper and necessary authorizations.
- Research project on effectiveness of disinfection treatments, filter efficacy after disinfection, and the reusability of respirators. In 2003-2005, CDC collaborated on and funded a project with the US Army to study respirator filtration efficiency against particulate and biological aerosols under moderate to high flow rates. A final report was issued in August 2006. The study found that biological aerosols (BG spores and MS phage virus simulant) were filtered at levels consistent with inert (non-biological) aerosols of the same aerodynamic diameter. The CDC has also initiated an FY07 research project to address the reusability and handling of FFRs.
- Research on use of surgical mask over N95 (one of the IOM-mentioned potential strategies). The CDC has initiated an FY07 research project to conduct laboratory studies using an automated breathing and metabolic simulator to measure metabolic gas concentrations inside the N95 FFR with and without a surgical mask. The institute of medicine recommended that individual users could reuse an N95 FFR if the respirator was protected from external surface contamination (e.g., using a surgical mask). This research project will determine what effect that recommendation has on the metabolic gas concentrations inside the respirator. A project protocol has been drafted and is in the process of being scientifically peer-reviewed.
- NIOSH support for increased inventory of N95s in SNS: NIOSH provided technical support to CDC Division of Strategic National Stockpile for the selection and purchase of appropriate N-95 respirators resulting in an inventory approximating 100 million respirators. NIOSH continues to work with the DSNS and participates on an HHS-wide work group to support CDC respirator needs.

CDC is initiating further action. NIOSH will:

- User guidance for healthcare workers and other user groups when research provides new information (part of Pandemic Preparedness tasks).
- Work with manufacturers and users on matching product availability with areas in need of supplies during a pandemic (part of Pandemic Preparedness tasks).
- Continue work with North Carolina State University (NCSU) is under contract evaluating shelf life. NCSU is studying filter media, not commercial respirators; none of the shelf-life data collected by NCSU has been published yet.

Item

**Minority Health Professions** – The Committee is pleased that CDC has continued to support the cooperative program with the Minority Health Professions Foundation and urges continued expansion of this activity, including sponsorship of public health and biomedical symposiums aimed at increasing career opportunities for minority students. (Page 99)

Action taken or to be taken

In FY 06, the Minority Health Professions Foundation was awarded \$669,800 to support minority student training programs including the Public Health Summer Fellows Program which exposes undergraduate students to

community-based opportunities and careers in public health, the Starlab Program which targets middle school and high school students, and Masters in Public Health Program operated by the Morehouse School of Medicine. Additionally, \$300,000 was provided to the Minority Health Professions Foundation to support their Annual Symposium on Career Opportunities in Biomedical Sciences which, in FY 06, attracted over 700 racially and ethnically diverse students from 20 states across the United States.

Item

**State and Local Capacity** – Funds for bioterrorism prevention and response are distributed through grants to 50 States and four metropolitan areas. The Committee strongly recommends that these funds be distributed based on a formula that includes factors for risk of a terrorist event. Risk is challenging to quantify, but the Committee suggests that CDC, in coordination with the Secretary of Health and Human Services, consider the following and other factors: (1) Site of headquarters or major offices of multinational organizations; (2) site of major financial markets; (3) site of previous incidents of international terrorism; (4) some measure of population density versus just population; (5) internationally recognized icons; (6) percent of national daily mass transit riders; (7) proximity to a major port, including major port ranked on number of cargo containers arriving at the port per year. (Page 100)

Action taken or to be taken

Currently, CDC calculates the variable portion of awards for the Public Health Emergency Preparedness Program using population (volume) only. We have, however, developed data sets similar to items 4, 6, and 7 above, and have access to additional classified and unclassified information related to items 1-3 and 5, as well as the Department of Homeland Security's model and methods. Decisions concerning the specific formula that will be used to distribute FY 2007 funds are pending interpretation of the Pandemic and All-Hazards Preparedness Act (P.L. 109-417) recently passed by Congress, which may prescribe the approach to be used.

Item

**Pacific Emergency Health Initiative** – The Committee recognizes that the Pacific Emergency Health Initiative [PEHI] may facilitate the disaster preparedness plans for the communities of the Republic of Palau, the U.S. Territories of Guam and American Samoa, the Commonwealth of Marianas Islands, the Federated States of Micronesia and the Republic of Marshall Islands. The Committee encourages CDC to consider supporting the Pacific Emergency Health Initiative for the completion and maintenance of emergency plans and training to fortify our Nation's westernmost Pacific borders against health threats associated with terrorist's acts, natural disasters and emerging diseases. Activities might include awareness of how to mitigate disease and deaths due to the aforementioned causes and the provision of data and tools essential for enhancing research studies in disaster management. The research derived from these experiences with disaster management will be useful in the development of standards of response in the Pacific and the U.S. mainland. The Pacific Emergency Health Initiative should coordinate these efforts with existing institutions such as the Pacific Island Health Officers Association, the World Health Organization, the Secretariat of Pacific Community and the U.S. Department of Defense. (Page 101)

Action taken or to be taken

Since its inception in 2000, CDC's Pacific Emergency Health Initiative (PEHI) has worked in close partnership with Pacific Island Countries and Territories (PICTs) to develop awareness and building capacity for disaster risk management throughout the region. Many of these important benchmarks occurred for the first time in Pacific history and are listed as follows:

- Performed public health vulnerability assessments in eleven PICTs.
- Completed all-hazard public health emergency plans for seven PICTs.
- Completed emergency plans for ten Pacific Island hospitals.
- Developed PEHI-NET, an Internet-based information and communication tool available to all PICTs.
- Trained more than 600 Pacific public health officials in emergency preparedness and response, including 6 Health Ministers and Secretaries of Health.
- Sponsored two special issues of the regional public health journal, Pacific Health Dialog.
- Established a fire protection training exchange program between the Republic of Palau and U.S.A. fire departments.
- Trained over 400 ambulance workers, doctors and nurses in seven PICTs.
- Provided emergency technical assistance to the Federated States of Micronesia in response to the 2002 Chuuk Micronesia landslide disaster.

- Hosted four international conferences on public health preparedness among the Pacific island nations.
- Developed and tested the CDC Automated Disaster and Emergency Planning Tool (ADEPT), an innovative approach to disaster planning, (which is now being used by U.S. state health departments and will likely benefit public health planning worldwide).
- Assisted all six US Associated Pacific Islands in preparing for bioterrorism through technical assistance in accomplishing terms of the CDC Public Health Bioterrorism Preparedness Cooperative Agreement.
- Organized three annual, simultaneous, multi-national emergency drills and exercises.
- Hosted the 2004 and 2005 Pacific Health Summits for Sustainable Disaster Risk Management. Public health leadership from all 22 PICTs developed attended a unified “Declaration for Sustainable Disaster Risk Management” And 16 concept papers for future funding and strategic planning.

CDC's Pacific Emergency Health Initiative (PEHI) will work in close partnership with US Associated Pacific Islands (USAPIs) and in coordination with existing institutions such as the Pacific Island Health Officers Association, the World Health Organization, the Secretariat of Pacific Community and the U.S. Department of Defense to fortify our Nation's westernmost Pacific borders against health threats associated with terrorist's acts, natural disasters and emerging diseases. Research derived from these experiences with disaster management will be applied towards the development of standards of response in the Pacific and the U.S. mainland.

Item

**[Respirator facemasks]** – . . . The Committee commends the Secretary for commissioning the Institute of Medicine to evaluate the potential development of reusable respirator facemasks in the event of an influenza pandemic. The Committee encourages the Secretary to consider comparative data regarding duration of effectiveness, range of tidal activity and shelf life for disposable NIOSH approved respirator facemasks with particulate filter, antimicrobial coated and antimicrobial iodinated technology, and to consider supply needs and issue end-user recommendations for such facemasks. (Page 101)

Action taken or to be taken

CDC has taken a number of actions to address respirator facemasks:

- Expedited N95 approval process of new products. The N95 filtering facepiece (FFR) approval process has been improved, reducing approval times for N95 particulate respirators from over 90 days to an average of 53 days. Five new FFR manufacturers received approvals in 2006.
- Program collaborations among NIOSH respirator certification, FDA and EPA programs for more efficient and expedient evaluation of products with antimicrobial treatments: NIOSH has instituted a policy to not approve antimicrobial claims unless the applicant has FDA and EPA approvals. The EPA approval must be an approval for use in the breathing zone and not an exemption. This directs the manufacturer to the proper agencies for evaluation of the efficacy and safety of any biocide treatments for which they intend to make claims. This utilizes existing programs in the EPA and FDA to assure product safety as well as validity of efficacy claims and ensure respirators making such claims have received all the proper and necessary authorizations.
- Research project on effectiveness of disinfection treatments, filter efficacy after disinfection, and the reusability of respirators. In 2003-2005, CDC collaborated on and funded a project with the US Army to study respirator filtration efficiency against particulate and biological aerosols under moderate to high flow rates. A final report was issued in August 2006. The study found that biological aerosols (BG spores and MS phage virus simulant) were filtered at levels consistent with inert (non-biological) aerosols of the same aerodynamic diameter. The CDC has also initiated an FY07 research project to address the reusability and handling of FFRs.
- Research on use of surgical mask over N95 (one of the IOM-mentioned potential strategies). The CDC has initiated an FY07 research project to conduct laboratory studies using an automated breathing and metabolic simulator to measure metabolic gas concentrations inside the N95 FFR with and without a surgical mask. The institute of medicine recommended that individual users could reuse an N95 FFR if the respirator was protected from external surface contamination (e.g., using a surgical mask). This research project will determine what effect that recommendation has on the metabolic gas concentrations inside the respirator. A project protocol has been drafted and is in the process of being scientifically peer-reviewed.

EXHIBITS  
SIGNIFICANT ITEMS IN APPROPRIATIONS REPORTS – SENATE

- NIOSH support for increased inventory of N95s in SNS: NIOSH provided technical support to CDC Division of Strategic National Stockpile for the selection and purchase of appropriate N-95 respirators resulting in an inventory approximating 100 million respirators. NIOSH continues to work with the DSNS and participates on an HHS-wide work group to support CDC respirator needs.

CDC is initiating further action. NIOSH will:

- User guidance for healthcare workers and other user groups when research provides new information (part of Pandemic Preparedness tasks).
- Work with manufacturers and users on matching product availability with areas in need of supplies during a pandemic (part of Pandemic Preparedness tasks).
- Continue work with North Carolina State University (NCSU) is under contract evaluating shelf life. NCSU is studying filter media, not commercial respirators; none of the shelf-life data collected by NCSU has been published yet.

Item

**Tobacco Harm Reduction** – According to a report published by the Institute of Medicine, even with the most intensive applications of the most effective known programs for prevention and cessation, approximately 15 percent of the adults in the United States are expected to continue to be regular smokers. Among this group are many who cannot or will not stop smoking, and it is to this group that effective programs and products of tobacco harm reduction should be directed. The Committee urges the Department to continue its review and discussion of products that could significantly reduce risk to individual smokers.

Action taken or to be taken

CDC and NIH collaborate on tobacco harm reduction through a series of networks and joint projects, including the Tobacco Harm Reduction Network and the WHO Tobacco Laboratory Network to develop a science base for a public health position on harm reduction that reduces disease and death for both individuals and the population as a whole. CDC continues a focus in its intramural laboratory on tobacco product research including new and emerging products. NIH is currently funding several investigator-initiated grants in areas related to tobacco product toxicity and harm reduction, combining basic laboratory science, surveillance, and behavioral research.

In 2006 the NCI awarded a five-year Research and Development contract to Georgetown University to develop laboratory methods and evaluate biomarkers and other measures for studying new tobacco products promoted to reduce harm. CDC scientists have participated as advisors to the development of this contract. CDC and NCI continue to conduct surveillance of consumer awareness, use and risk perceptions related to different types of tobacco products.

Item

**HIV Rapid Testing Initiative** – The Committee commends the Secretary for the HHS initiative on increased rapid HIV testing for HIV/AIDS. The Committee is aware that wide-scale bulk deployment of new oral fluid rapid HIV testing for HIV is a significant step towards helping citizens throughout the United States, to know their HIV status. The Committee urges the Secretary to significantly increase the use of bulk purchasing and wide-scale deployment of FDA-approved oral fluid HIV rapid tests for all domestic HIV prevention initiatives. (Page 216)

Action taken or to be taken

In Fiscal Year 2006, CDC purchased 211,800 OraQuick Advance HIV 1/2 Tests that were provided to state health department partners. CDC encourages its partners to use HIV prevention funds to make individual purchases of rapid HIV tests.

**AUTHORIZING LEGISLATION**

DOLLARS IN THOUSANDS	FY 2007 AMOUNT AUTHORIZED	FY 2007 CR	FY 2008 AMOUNT AUTHORIZED	FY 2008 BUDGET REQUEST
<b>Infectious Diseases:</b>				
Immunization and Respiratory Diseases	Indefinite	\$490,527	Indefinite	\$544,977
PHSA §§ 301, 307, 310, 311, 317, 317(a), 317(j), 317(j)(1) <sup>3</sup> , 317(k)(1), 319, 319E, 327, 340C, 352, 2102 (6), 2102(7) 2125, 2126, 2127, Title XXI 1928 of Social Security Act (42 U.S.C 1396s)				
HIV/AIDS, Viral Hepatitis, STD, and TB Prevention	Indefinite	\$963,798	Indefinite	\$1,056,798
PHSA §§ 301, 301(a), 301(d), 3061, 307, 308(d), 310, 311, 317 <sup>3</sup> , 317(a), 317P, 318 <sup>1</sup> , 318A <sup>1</sup> , 318B <sup>3</sup> , 322, 325, 327, 352, 1102, 2315, 2317, 2320, 2341, 2500-2514, 2521 <sup>1</sup> - 2524 <sup>1</sup> , 2625 <sup>3</sup> Provisions Concerning Pregnancy and Perinatal Transmission of HIV [2625(c)] <sup>3</sup> Tuskegee Health Benefits: P.L. 103-333 Ryan White CARE Act Amendments: § 502 of P.L. 106-345 <sup>3</sup> International authorities: P.L. 109-149 sec. 215				
Zoonotic, Vector-Borne, and Enteric Diseases	Indefinite	\$79,852	Indefinite	\$62,952
PHSA §§ 301, 307, 310, 311, 317, 317P, 317R, 317S, 319, 319E, 319F <sup>4</sup> , 319G <sup>4</sup> , 322, 327, 352, 361-363, 1102, 1182, 1222 Immigration and Nationality Act §§ 212, 213				
Preparedness, Detection, and Control of Infectious Diseases	Indefinite	\$124,449	Indefinite	\$129,641
PHSA §§ 301, 307, 310, 311, 317 <sup>3</sup> , 317N <sup>3</sup> , 317S <sup>5</sup> , 319, 322, 325, 327, 352, 361-369, Immigration and Nationality Act §§ 212, 232				
<b>Health Promotion:</b>				
Chronic Disease Prevention, Health Promotion, and Genomics	Indefinite	\$834,150	Indefinite	\$834,195
PHSA §§ 301, 307, 310, 311, 317 <sup>3</sup> , 317D <sup>2</sup> , 317C <sup>5</sup> , 317H <sup>3</sup> , 317K <sup>3</sup> , 317K(a) <sup>3</sup> , 317K(b) <sup>3</sup> , 317L <sup>3</sup> , 317M <sup>3</sup> , 327, 340D, 352, 391 <sup>3</sup> , 399B-399D <sup>2</sup> , 399F <sup>1</sup> , 399H-399L, 399W-399Z <sup>3</sup> , 419C, 1102, 1501-1510 <sup>1</sup> , 1702(a)(2), 1702(a)(3), 1702(4)(A) and 1702(4)(C), 1703(a)(1), 1703(a)(2), 1703(a)(3), 1703(a)(4), 1703(c), 1704(1), 1704(2), 1704(3), 1706 <sup>1</sup> Comprehensive Smoking Education Act of 1984 Comprehensive Smokeless Tobacco Health Education Act of 1986 Fertility Clinic Success Rate and Certification Act of 1992 Asthmatic Schoolchildren's Treatment and				

DOLLARS IN THOUSANDS	FY 2007 AMOUNT AUTHORIZED	FY 2007 CR	FY 2008 AMOUNT AUTHORIZED	FY 2008 BUDGET REQUEST
Health Management Act of 2004 <sup>7</sup> Benign Brain Tumor Cancer Registries Amendment Act <sup>5</sup> Breast and Cervical Cancer Mortality Prevention Act Prematurity Research Expansion and Education for Mothers who Deliver Infants Early Act (S. 707)				
Birth Defects, Developmental Disabilities, Disabilities & Health	Indefinite	\$124,537	Indefinite	\$124,537
PHSA §§ 301,307,310,311,317 <sup>3</sup> , 317C <sup>5</sup> , 317J <sup>3</sup> , 327, 352, 399G, 399H, 399I, 399J, 399M <sup>1</sup> ,1102, 1108 <sup>3</sup> PHSA Title IV <sup>3</sup>				
<b>Health Information and Service:</b>				
Health Statistics	Indefinite	\$109,021	Indefinite	\$109,921
PHSA §§ 301, 304, 306 <sup>1</sup> 307, 308 1% Evaluation: PHSA § 241 (non-add) (Superseded in the FY 2002 Labor HHS Appropriations Act - Section 206)	Not more than 1.25% of amounts appropriated for PHSA programs as determined by the Secretary		Not more than 1.25% of amounts appropriated for PHSA programs as determined by the Secretary	
Public Health Informatics	Indefinite	\$70,272	Indefinite	\$94,402
PHSA §§ 301, 304, 306 <sup>1</sup> , 308, 307, 310, 311, 317 <sup>3</sup> , 318 <sup>1</sup> , 319, 319A <sup>4</sup> , 319B <sup>1</sup> , 319C <sup>4</sup> , 327, 352, 391 <sup>3</sup> , 1102, 2315, 2341, Clinical Laboratory Improvement Amendments of 1988, § 4				
Health Marketing	Indefinite	\$39,673	Indefinite	\$39,173
§§ 301, 304, 306 <sup>1</sup> , 308, 307, 310, 311, 317 <sup>3</sup> , 318 <sup>1</sup> , 319, 319A <sup>4</sup> , 319B <sup>1</sup> , 319C <sup>4</sup> , 327, 352, 391 <sup>3</sup> , 1102, 2315, 2341, Title XVII: 1702(a)2, 1702(a)3, 1702(4)(A), 1702(4)(C), 1703(a)(1), 1703(a)(2), 1703(a)(3), 1703(a)(4), 1703(c), 1704(1), 1704(2), 1704(3), 1704(6), 1706, Clinical Laboratory Improvement Amendments of 1988, § 4				
<b>Environmental Health and Injury:</b>				
Environmental Health	Indefinite	\$149,264	Indefinite	\$149,264
PHSA §§ 301, 307, 310, 311, 317 <sup>3</sup> , 317A <sup>3</sup> , 317B, 317I <sup>3</sup> , 327, 352, 361, 1102 Housing and Community Development Act, 1021 (15 U.S.C. 2685) Title 50 – sections 1512 and 1521 of the Chemical Weapons Elimination Activities Housing and Community Development (Lead Abatement) Act of 1992 (42 U.S.C. § 4851 et seq.)				
Injury Prevention and Control	Indefinite	\$138,410	Indefinite	\$138,410

DOLLARS IN THOUSANDS	FY 2007 AMOUNT AUTHORIZED	FY 2007 CR	FY 2008 AMOUNT AUTHORIZED	FY 2008 BUDGET REQUEST
PHSA §§ 301, 307, 310, 311, 317 <sup>3</sup> , 319, 327, 352, 391-394A <sup>3</sup> , 1252 Use of Allotments for Rape Prevention Education (393B <sup>3</sup> ) Section 4, P.L. 104-166 (expired) Sec 413 of the Family Violence Prevention and Services Act of 2003 <sup>6</sup>				
<b>Occupational Safety and Health:</b>				
Occupational Safety and Health	Indefinite	\$252,999	Indefinite	\$252,998
PHSA §§ 301, 304, 306 <sup>1</sup> , 307, 310, 311, 317 <sup>3</sup> , 317A <sup>3</sup> , 317B, 327 Occupational Safety and Health Act of 1970 (P.L. 91-596), §§ 9, 20-22 (29 USC 657) Federal Mine Safety and Health Act of 1977, P.L. 91-173 as amended by P.L. 95-164, §§ 101, 102, 103, 202, 203, 204, 205, 206, 301, 501, 502, 508 and PL 95-239 § 19 (30 USC 904) Federal Fire Prevention and Control Act, § 209, (29 U.S.C. 671(a)) Radiation Exposure Compensation Act, §§ 6 and 12(42 U.S.C. 2210) Housing and Community Development Act of 1922 §1021 (15 U.S.C. 2685) Energy Employees Occupational Illness Compensation Program Act (2000) 42 U.S.C. 7384, et. Seq. (as amended) Floyd D. Spence National Defense Authorization Act §§ 3611, 3612, 3623, 3624, 3625, 3626 of P.L. 106-393 National Defense Authorization Act for Fiscal Year 2006, PL 109-163 Toxic Substances Control Act (15 USC 2682) Prohibition of Age Discrimination Act (29 USC 623) Mine Improvement and New Emergency Response Act of 2006 (MINER Act), P.L. 109-236 (29 U.S.C. 671, 30 U.S.C. 963 and 965) §§ 6, 11 and 13				
<b>Global Health:</b>				
Global Health	Indefinite	\$310,420	Indefinite	\$379,719
PHSA §§ 301, 304, 307, 310, 319, 327, 340C, 361-369, 2315, 2341 Foreign Assistance Act of 1961 §§ 104, 627, 628 Federal Employee International Organization Service Act § 3 International Health Research Act of 1960 § 5 Agriculture Trade Development and Assistance Act of 1954 § 104 Economy Act				

EXHIBITS  
AUTHORIZING LEGISLATION

DOLLARS IN THOUSANDS	FY 2007 AMOUNT AUTHORIZED	FY 2007 CR	FY 2008 AMOUNT AUTHORIZED	FY 2008 BUDGET REQUEST
22 U.S.C. 3968 Foreign Employees Compensation Program 41 U.S.C. 253 International Competition Requirement Exception) P.L. 107-116 sec. 215 HR 5656 § 220 FY 2001 Appropriations Bill				
<b>Public Health Research:</b>				
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	
<b>Public Health Improvement and Leadership:</b>				
Public Health Improvement	Indefinite	\$189,236	Indefinite	\$190,412
PHSA §§ 301, 304, 306 <sup>1</sup> , 307, 308, 310, 311, 317, 317(F), 319, 319A <sup>4</sup> , 322, 325, 327, 352, 361-369, 391 <sup>3</sup> , 399(F), 399G, 1102, 2315, 2341 Federal Technology Transfer Act of 1986, (15 U.S.C. 3710) Bayh-Dole Act of 1980, P.L. 96-517 Clinical Laboratory Improvement Amendments of 1988, § 4				
<b>Preventive Health and Health Services Block Grant:</b>				
Preventive Health and Health Services Block Grant	Indefinite	\$99,000	Indefinite	\$0
Grants: PHSA Title XIX <sup>1</sup> Prevention Activities: PHSA §§ 214, 301, 304, 306 <sup>1</sup> , 307, 308, 310, 311, 317J <sup>3</sup> , 327 Violent Crime Reduction Programs 40151 of P.L. 103-322				
<b>Buildings and Facilities:</b>				
Buildings and Facilities	Indefinite	\$133,638	Indefinite	\$20,000
PHSA §§ 304 (b)(4), 319D <sup>4</sup> , 321(a)				
<b>Business Services Support:</b>				
Business Services Support	Indefinite	\$317,781	Indefinite	\$319,877
PHSA §§ 301, 304, 307, 310, 317 <sup>3</sup> , 317F <sup>1</sup> , 319, 327, 361, 362, 368, 399F <sup>1</sup> Federal Technology Transfer Act of 1986, (15 U.S.C. 3710) Bayh-Dole Act of 1980, P.L. 96-517				

DOLLARS IN THOUSANDS	FY 2007 AMOUNT AUTHORIZED	FY 2007 CR	FY 2008 AMOUNT AUTHORIZED	FY 2008 BUDGET REQUEST
<b>Terrorism:</b>				
Terrorism  PHSA §§ 301, 307, 311, 317 <sup>3</sup> , 319, 319A <sup>4</sup> , 319C, 319D <sup>4</sup> , 319F <sup>4</sup> , 319F(2) 319G <sup>4</sup> , 361-368 (42 U.S.C. 262 note), 2801-2811. Public Health Security and Bioterrorism Preparedness and Response Act of 2002. Pandemic and All-Hazards Preparedness Act (P.L. 109-417)	Indefinite	\$1,543,947	Indefinite	\$1,504,375
<b>Reimbursables and Trust Funds: (non-add)</b>				
PHSA §§ 301, 306(b)(4) <sup>1</sup> , 353 Clinical Laboratory Improvement Act User fee: Labor-HHS FY Appropriations	Indefinite		Indefinite	
<b>Agency for Toxic Substances and Disease Registry:</b>				
ATSDR  The Great Lakes Critical Programs Act of 1990, 33 U.S.C. § 1268 Section 104(i) of the Comprehensive Environmental Response, Compensation and Liability Act of 1980 (CERCLA), as amended by the Superfund Amendments and Reauthorization Act of 1986 (SARA), 42 U.S.C § 9604(i) The Defense Environmental Restoration Program, 10 U.S.C. § 2704 The Resource Conservation and Recovery Act, as amended, 42 U.S.C § 321 et seq. The Clean Air Act, as amended, 42 U.S.C. § 7401 et seq.	Indefinite	\$74,905	Indefinite	\$75,004
<b>Total Appropriation</b>		<b>\$6,076,879</b>		<b>\$6,057,655</b>

## APPROPRIATIONS HISTORY

<b>FY 2008 BUDGET SUBMISSION</b> <b>CENTERS FOR DISEASE CONTROL AND PREVENTION<sup>1</sup></b> <b>APPROPRIATION HISTORY TABLE</b> <b>DISEASE CONTROL, RESEARCH, AND TRAINING</b>				
	<b>Estimate</b>	<b>House Allowance</b>	<b>Senate Allowance</b>	<b>Appropriation</b>
1997	2,229,900,000	2,187,018,000	2,209,950,000	2,302,168,000 <sup>2</sup>
1998	2,316,317,000 <sup>3</sup>	2,388,737,000	2,368,133,000	2,374,625,000 <sup>4</sup>
1998 Supplemental	--	--	--	9,000,000 <sup>5</sup>
1999	2,457,197,000	2,591,433,000	2,366,644,000 <sup>6</sup>	2,609,520,000 <sup>7</sup>
1999 Offset	--	--	--	(2,800,000) <sup>8</sup>
1999 Resc./1% Transfer	--	--	--	(3,539,000)
2000	2,855,440,000 <sup>9</sup>	2,810,476,000	2,802,838,000	2,961,761,000 <sup>10</sup>
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 <sup>11</sup>
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 <sup>12</sup>	--	--	--	16,000,000
2004 <sup>13</sup>	4,157,330,000	4,538,689,000	4,494,496,000	4,367,165,000
2005 <sup>13 14</sup>	4,213,553,000	4,228,778,000	4,538,592,000	4,533,911,000
2005 Labor/HHS Reduction	--	--	--	(1,944,000)
2005 Rescission	--	--	--	(36,256,000)
2005 Supplemental <sup>14</sup>	--	--	--	15,000,000
2006 <sup>13 15</sup>	3,910,963,000	5,945,991,000	6,064,115,000	5,884,934,000
2006 Rescission	--	--	--	(58,848,000)
2006 Suplemental <sup>16</sup>	--	--	--	275,000,000
2006 Supplemental <sup>17</sup>	--	--	--	218,000,000
2006 Section 202 Transfer to CMS	--	--	--	(4,002,000)
2007 <sup>13 15 16 18</sup>	5,783,205,000	6,073,503,000	6,095,900,000	5,736,913,000
2008 <sup>13 15</sup>	5,716,690,000	--	--	--

<sup>1</sup>Does not include funding for ATSDR

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

<sup>3</sup>Includes \$522,000 supplemental increase for ICASS activities.

<sup>4</sup>Includes \$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.

<sup>5</sup>This supplemental increase was provided for emergency Polio eradication efforts in Africa.

<sup>6</sup>Does 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.

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

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

<sup>9</sup>Revised 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.

<sup>10</sup>Does 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.

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

<sup>12</sup>Emergency Wartime Supplemental Appropriations Act, 2003 PL 108-11 for SARS

<sup>13</sup>FY 2004, FY 2005, FY 2006, FY 2007 and FY 2008 funding levels for the Estimate reflect the Proposed Law for Immunization.

<sup>14</sup>FY 2005 includes a one time supplemental of \$15,000,000 for avian influenza through the Emergency Supplemental Appropriations Act for Defense, the Global War on Terror, and Tsunami Relief, 2005.

<sup>15</sup>Beginning in FY 2006, Terrorism funds are directly appropriated to CDC instead of being appropriated to the Public Health and Social Service Emergency Fund (PHSSEF). As a result, FY 2006 House, Senate, and Appropriation totals include Terrorism funds. The FY 2007 and FY 2008 levels also include Terrorism funding.

<sup>16</sup>FY 2006 includes a one-time supplemental of \$275 million for pandemic influenza and World Trade Center activities through P.L.109-141, Department of Defense Emergency Supplemental Appropriations to Address Hurricanes in the Gulf of Mexico, and Pandemic Influenza Act, 2006

<sup>17</sup>FY 2006 includes a one time supplemental of \$218 million for pandemic influenza, mining safety, and mosquito abatement through P.L. 109-234, Emergency Supplemental Appropriations Act for Defense, the Global War on Terror, and Hurricane Recovery, 2006.

<sup>18</sup>The FY 2007 appropriation amount listed is the FY 2007 estimated CR level based on a year long Continuing Resolution.

<b>FY 2008 BUDGET SUBMISSION</b> <b>CENTERS FOR DISEASE CONTROL AND PREVENTION<sup>1</sup></b> <b>APPROPRIATION HISTORY TABLE</b> <b>TERRORISM FUNDING</b>				
	Estimate	House Allowance	Senate Allowance	Appropriation
1999	--	43,000,000 <sup>1</sup>	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 <sup>2</sup>	--	--	--	2,070,000,000
2002 Rescission <sup>3</sup>	--	--	--	(396,000)
2003 <sup>4</sup>	1,116,740,000	1,522,940,000	1,536,740,000	1,543,440,000
2003 Recission				(10,032,000)
2003 Transfer <sup>5</sup>	(400,000,000)	--	--	--
2004 <sup>4</sup>	1,116,156,000	1,116,156,000	1,116,156,000	1,116,156,000
2004 Recission				(6,585,000)
2004 Transfer <sup>6</sup>		--	--	400,584,000
2005	1,509,571,000	1,637,760,000	1,639,571,000	1,577,612,000
2005 Labor/HHS Reduction	--	--	--	(271,000)
2005 Rescission	--	--	--	(12,584,000)
2005 Supplemental <sup>7</sup>	--	--	--	58,000,000
2006 <sup>8,9</sup>	1,796,723,000	--	--	--

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

<sup>2</sup>Public Health and Social Services Emergency Fund

<sup>3</sup>Administrative and Related Expenses Reduction.

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

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

<sup>6</sup>Same transfer as FY 2003 to the Department of Homeland Security, plus an additional \$584,000 for internal support

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

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

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

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# **NARRATIVE BY ACTIVITY**

## INFECTIOUS DISEASES

Infectious Diseases (Dollars in Thousands)	FY 2006 Actual	FY 2007 CR	FY 2008 Budget	FY 2008 +/- FY 2007
BA	\$1,682,362	\$1,645,832	\$1,781,574	\$135,742
PHS Evaluation Transfers	\$12,794	\$12,794	\$12,794	\$0
Total	<b>\$1,695,156</b>	<b>\$1,658,626</b>	<b>\$1,794,368</b>	<b>\$135,742</b>

### INTRODUCTION

The Infectious Diseases budget activity was formally redistributed in FY 2007 as part of an organizational design to integrate science, program, epidemiology and laboratory activities as well as focus on enhancing cross-organizational activities to enhance efficiency and service. Continued infectious disease coordination will ensure infectious disease programs are based on the highest standards of quality, equity, and integrity as well as ensuring excellent service to CDC's customers.

In FY 2005, the Coordinating Center for Infectious Diseases (CCID) began a process of revisiting its structure to more closely align programs working in related areas, using similar prevention strategies, and engaging common partners and stakeholders. During those discussions, it was determined that the coordinating center would be most effective by moving to a four-center structure rather than the existing three centers.

The four-center structure (and associated budgets) are organized around vaccine preventable diseases, routes of disease transmission (food-borne/water-borne/zoonotic and sexually transmitted diseases), and preparedness and response functions. The new budget categories within Infectious Diseases are: 1) Immunization and Respiratory Diseases, 2) HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, 3) Zoonotic, Vector-Borne, and Enteric Diseases, and 4) Preparedness, Detection, and Control of Infectious Diseases.

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. Infectious diseases are a continuing threat to our nation's health and having a healthy nation is having a defendable nation.

CDC's Infectious Diseases activities include responsibilities for:

- Investigating infectious disease outbreaks;
- Enhancing preparedness for infectious disease areas, such as pandemic influenza, by building epidemiology and laboratory capacity;
- Developing domestic and global capacity for recognizing and responding to infectious diseases and protecting the health of Americans at home and abroad;
- Developing, implementing, and evaluating effective science-based infectious disease prevention programs in areas such as HIV/AIDS, sexually transmitted diseases, and tuberculosis;
- Conducting national surveillance activities to track infectious diseases and understand their public health dynamics;
- Preventing disease, disability and death in children, adolescents and adults through safe and effective vaccination;
- Providing technical, epidemiological, educational, statistical and scientific assistance to state and local health departments concerning infectious diseases;
- Developing high quality research and translating relevant finds into infectious disease prevention policy and programs;
- Strengthening and promoting surveillance activities and findings for program planning, public health response and evaluation.

In FY 2008, CDC will integrate science, program, epidemiology and laboratory activities as well as focus on enhancing cross-organizational activities to enhance efficiency and service. Continued infectious disease coordination will ensure infectious disease programs are based on the highest standards of quality, equity and integrity as well as ensuring excellent service to CDC's customers.

## **IMMUNIZATION AND RESPIRATORY DISEASES**

### **AUTHORIZING LEGISLATION**

PHSA §§ 301, 307, 310, 311, 317, 317(a), 317(j), 317(j)(1)<sup>3</sup>, 317(k)(1), 319, 319E, 327, 340C, 352, 2102 (6), 2102(7) 2125, 2126, 2127, Title XXI, 1928 of Social Security Act (42 U.S.C 1396s)

<b>Immunization and Respiratory Diseases (Dollars in Thousands)</b>	<b>FY 2006 Actual</b>	<b>FY 2007 CR</b>	<b>FY 2008 Budget</b>	<b>FY 2008 +/- FY 2007</b>
Discretionary Immunization and Respiratory Diseases Program	\$507,064	\$477,733	\$532,183	\$54,450
<i>Section 241, PHS Evaluation Transfer</i>	<i>\$12,794</i>	<i>\$12,794</i>	<i>\$12,794</i>	<i>\$0</i>
<b><i>Subtotal, Discretionary Immunization Program</i></b>	<b><i>\$519,858</i></b>	<b><i>\$490,527</i></b>	<b><i>\$544,977</i></b>	<b><i>\$54,450</i></b>
Vaccines for Children (VFC)	\$1,974,295	\$2,905,330	\$2,761,957	(\$143,373)
<b>Total Immunization and Respiratory Diseases</b>	<b>\$2,494,153</b>	<b>\$3,395,857</b>	<b>\$3,306,934</b>	(\$88,923)

### **STATEMENT OF THE BUDGET**

The FY 2008 total Budget of \$3,306,934,000 for Immunization and Respiratory Diseases reflects a decrease of \$88,923,000 below the FY 2007 Continuing Resolution of \$3,395,857,000. The FY 2008 Budget of \$544,977,000 for the discretionary Immunization and Respiratory Diseases program reflects an increase of \$54,450,000 above the FY 2007 Continuing Resolution of \$490,527,000. The FY 2008 estimate of \$2,761,957,000 for the VFC program reflects a decrease of \$143,373,000 below the FY 2007 estimate of \$2,905,330,000.

### **PROGRAM DESCRIPTION**

CDC strives to prevent disease, disability, and death through immunization and by control of respiratory and related diseases. Strategic priorities of Immunization and Respiratory Diseases program include:

- Improve infant, child, adolescent and adult immunization programs by:
  - Increasing coverage of recommended vaccines while eliminating disparities (e.g., racial/ethnic or financial),
  - Strengthening systems to assure adolescent and adult immunization, and
  - Improving effectiveness and efficiencies of state immunization programs.
- Establish and/or strengthen systems to evaluate effectiveness of national policies for immunization and respiratory disease prevention and control.
- Accelerate and sustain reduction of vaccine-preventable diseases domestically and globally through improved use of available vaccines, research and development of new vaccines, and program monitoring (including, as appropriate, surveillance).
- Reduce burden of complications associated with pneumonia and influenza.
- Improve preparedness for pandemic influenza with a strategy that will improve response to seasonal influenza.
- Improve national, state, local and global public health capacity to respond to outbreaks of respiratory and related diseases (e.g., reduce time to detect, investigate, respond, control, and recover).
- Identify and promote evidence-based strategies for reducing respiratory and related infections, vaccine-preventable diseases, and for controlling antimicrobial resistance in communities.

NARRATIVE BY ACTIVITY  
INFECTIOUS DISEASES  
IMMUNIZATION AND RESPIRATORY DISEASES

- Improve CDC's ability to identify and characterize the cause of respiratory and related infectious disease syndromes.

The related diseases for which this new organization will have primary responsibility for CDC include gastroenteritis (e.g., norovirus), non-vaccine preventable disease herpes viruses (e.g., Cytomegalovirus), non-respiratory Streptococci (e.g., group B, C, and G streptococcus), and community-acquired neonatal sepsis.

CDC's ongoing commitment to immunization and control of respiratory and related diseases is an essential component of its public health mission. Many life-threatening and/or debilitating infectious diseases, including polio, diphtheria, measles, *Haemophilus influenzae* type b (Hib), and pertussis, were once common in this country. Now, widespread use of vaccines, particularly among children, has resulted in elimination or low levels of these diseases. Appropriate administration of safe and effective vaccines is one of the most successful and cost-effective public health tools for preventing disease, disability, and death and for reducing economic costs resulting from vaccine-preventable diseases. To maintain the success of the immunization program, CDC provides national leadership in the ongoing effort to protect children, adolescents and adults from vaccine-preventable diseases and to ensure the safety of vaccines. These responsibilities focus on the goal of ensuring that every person, of every age, in every part of the country is protected from vaccine-preventable diseases.

CDC strives to ensure control of vaccine-preventable diseases by working with partners to: develop national immunization policy; ensure high quality immunization infrastructure and services; increase community participation, education and partnerships; improve systems to detect and monitor disease; improve vaccination coverage, vaccine effectiveness, and immunization safety; improve vaccines and vaccine use; and, provide vaccine to millions of children, adolescents, and adults annually who otherwise could not afford them.

Both seasonal and pandemic influenza represent substantial threats to the U.S. and global populations. Preparation to prevent, detect and conduct surveillance of seasonal influenza translates into enhanced preparedness for pandemic influenza. Every year in the United States, on average, more than 200,000 people are hospitalized from influenza complications and about 36,000 people die from influenza. Although seasonal influenza most adversely affects young children, elderly, and those with chronic illness, it impacts Americans at every stage of life. The health consequences of an influenza pandemic would be even more severe. CDC's ongoing activities include conducting and supporting research on influenza to understand who is at greatest risk of complications and how best to prevent those complications; monitoring the onset and spread of seasonal and pandemic influenza; conducting surveillance that monitors changes in the influenza viruses and advises development of seasonal influenza vaccines and candidate vaccines for pandemic preparedness; conducting research to improve effectiveness of influenza vaccines and other means to prevent and treat influenza; and developing strategies for the early detection and control of pandemic influenza globally.

CDC is working throughout the world, in support of the President's National Strategy on Pandemic Influenza, the Health and Human Services Pandemic Influenza Plan, and other initiatives to ensure that the U.S. is prepared for an influenza pandemic. Internationally, the focus is on the development of capacity for surveillance and rapid response to increase the chances for identification of early case and clusters that may lead to a pandemic, thus increasing the possibility of slowing or stopping the spread of a new pandemic influenza virus.

For many cases of serious infectious diseases, the cause remains unknown. CDC is at the forefront of pathogen discovery and detection, using the latest technology to identify and characterize both known and previously unrecognized infectious agents. CDC's laboratories played a key role in rapidly identifying a new coronavirus linked with the 2003 global outbreak of severe acute respiratory syndrome (SARS), a new nipah virus, and multiple new picornaviruses, many of which caused serious disease. These laboratories also focus on developing state-of-the-art technologies to enhance detection of known pathogens to improve outbreak detection and appropriately focus response efforts. As the effects of international travel, global commerce, and changing ecosystems continue to provide new opportunities for the emergence and rapid spread of new pathogens, new methods and capabilities of detecting these threats are urgently needed.

NARRATIVE BY ACTIVITY  
INFECTIOUS DISEASES  
IMMUNIZATION AND RESPIRATORY DISEASES

In carrying out its mission CDC:

- Awards grants through the Section 317 of the Public Health Service Act and the Vaccines for Children (VFC) program to assist state and local health departments in purchasing safe and effective vaccines and in planning, developing, and conducting immunization programs.
  - The VFC program serves children and adolescents without insurance, those eligible for Medicaid, American Indian/Alaska Native children, and children who are underinsured and receive care through Federally Qualified Health Clinics, and Rural Health Centers. Through the VFC program, federally purchased vaccines are distributed to public health clinics and enrolled private providers, enabling vaccination of all eligible children.
  - 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) or insured but cannot afford high deductibles (i.e. the working poor). Vaccines are provided to adolescents and adults, as funding allows, but to a much lesser extent than children.
- Provides technical, epidemiological, laboratory, statistical, scientific and educational assistance to state and local health departments.
- Supports national and sentinel surveillance as well as laboratory confirmation of diseases for which effective immunization agents are available.
- Implements strategies during the seasonal influenza season that will ultimately improve capacity in the event of an influenza pandemic. Strategies include: reducing disease burden, improving provider and patient expectations regarding influenza supply, improving predictability of vaccine supply, demand, and distribution; improving laboratory and epidemiologic capacity at local and state levels; strengthening linkages between health care sector and public health.
- Works to ensure the safety of recommended vaccines by monitoring harmful effects, conducting scientific research to evaluate the safety of vaccines, and communicating the benefits and risks of vaccines to the public.
- Encourages external participation in its immunization safety research agenda: collaborates with the National Vaccine Program Office and its National Vaccine Advisory Committee to solicit external scientific comments in the development of its Vaccine Safety Datalink (VSD) research agenda.
- Establishing an extramural immunization safety research activity to support investigator-initiated, peer-reviewed external research into genetic susceptibility to adverse events following routine immunizations.

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

For every \$1 spent on an individual vaccine:

Diphtheria-Tetanus-acellular Pertussis (DTaP) saves \$27

Measles, Mumps, and Rubella (MMR) saves \$26

Perinatal Hepatitis B saves \$14.70

Varicella saves \$5.40

Inactivated Polio (IPV) saves \$5.45

For every \$1 spent:

Childhood Series (7 vaccines) saves \$16.50<sup>1</sup>

<sup>1</sup> (Series includes DTaP, Td, Hib, IPV, MMR, Hep B and Varicella)

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

NARRATIVE BY ACTIVITY  
INFECTIOUS DISEASES  
IMMUNIZATION AND RESPIRATORY DISEASES

Despite great success and achievements in immunization and the control of respiratory diseases, there are challenges:

- Every day in the U.S. approximately 11,000 babies are born who will need as many as 28 vaccinations before they are two years of age to be protected against 14 vaccine-preventable diseases. Nearly one million two-year-olds in the U.S. 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.
- In 1983, vaccines for seven diseases were available and recommended for routine use in children in the U.S. By January 2007, vaccines for 16 diseases were available and routinely recommended for children and adolescents. With these new recommendations for immunizations, it is now estimated to cost \$1,181.60 to fully immunize a female through age eighteen and \$894 to fully immunize a male through age eighteen with the complete set of Advisory Committee on Immunization Practices (ACIP) recommended vaccines (the difference between males and females is related to the human papillomavirus vaccine (HPV), which is currently recommended for females only).
- The ACIP recommended the newly licensed HPV vaccine for the routine vaccination of 11-12 year old girls in 2006. This vaccine targets HPV types that cause up to 70 percent of all cervical cancers. HPV is a cause of cervical cancer, which kills approximately 3,700 women annually in the United States.
- While the pneumococcal conjugate vaccine (PCV) has dramatically reduced the number of pneumococcal infections caused by resistant strains, strains not covered by the vaccine are emerging and some are highly resistant to multiple antibiotics.
- In contrast to children, the burden of vaccine-preventable diseases in adults in the United States remains high. Approximately 46,700 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. A major challenge related to immunizations is extending the success in childhood immunization to the adult population. The ACIP also recently recommended a newly licensed vaccine against herpes zoster (shingles) in individuals 60 years of age and older.
- With the recent widespread outbreaks of avian influenza in poultry and wild migratory birds in Asia, Eastern Europe, and Africa and ongoing reported human deaths due to infections with avian A (H5N1) influenza, CDC must be vigilant in the surveillance for avian viruses and other novel influenza viruses that may adapt and become easily transmissible in humans. The health consequences of an influenza pandemic would be severe. Modeling studies suggest that, in the absence of any control measures, a “medium-level” pandemic in the U.S. could result in an estimated 89,000 – 207,000 deaths, 314,000 – 734,000 hospitalizations, 18 – 42 million outpatient visits, and another 20 – 47 million people being sick if 15 – 35 percent of the U.S. population develops influenza. The associated economic impact on the U.S. could range from \$71 – \$167 billion. A severe pandemic could result in up to 1.9 million deaths.
- Although more than 200 million individuals are recommended to receive annual influenza vaccine, supply and demand have not caught up with these recommendations and uptake remains below optimal. In the 2005-2006 influenza season, more than 81 million doses were distributed; however, approximately 88 million were produced. For the 2006-2007 influenza season, vaccine manufacturers produced more than 100 million doses of influenza vaccine, a record production level. It is unknown how much vaccine has been administered to date. In order to keep high levels of supply and demand for influenza vaccine, CDC works closely with partners in the public and private sectors to increase demand in the offices of healthcare providers and among individuals for whom the vaccine is recommended and to address provider and public expectations regarding the timing of vaccine availability given the uncertainties involved in phased influenza vaccine distribution. Although vaccine distribution is mostly a private sector enterprise, CDC works to influence influenza vaccine distribution and use through recommendations, guidelines, and extensive collaborations.
- Immunizations are subject to a higher standard of safety than other medical interventions because they are given to healthy people. Actively monitoring and assuring the safety of vaccines is essential for maintaining public confidence in immunizations, thereby preserving high coverage levels and preventing a resurgence of vaccine-preventable diseases.

**NARRATIVE BY ACTIVITY**  
**INFECTIOUS DISEASES**  
**IMMUNIZATION AND RESPIRATORY DISEASES**

CDC is committed to:

- Ensuring that childhood immunizations remain at high levels so the incidence of vaccine-preventable diseases continues to decline significantly.
- Achieving high vaccination coverage rates for adolescents especially for newly recommended vaccines. CDC is strengthening the delivery of vaccines to adolescents by identifying adolescent health care providers and integrating these new vaccines into the delivery of other clinical preventive services recommended for them.
- Providing effective, proactive leadership on vaccines and immunization 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. This includes the development of a childhood and adolescent routine immunization schedule with the ACIP, the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP). CDC also works to develop a single routine Adult Immunization Schedule endorsed by ACIP, AAFP, and the American College of Obstetricians and Gynecologists. Both schedules are continually evaluated to ensure the highest level of effectiveness, efficiency and safety.
- Supporting national and global influenza pandemic preparedness through technical assistance offered on influenza surveillance, laboratory detection and confirmation, and guidance on incorporating effective immunization practices into pandemic preparedness and emergency response plans.
- Providing assistance to state and local health departments to investigate outbreaks of disease and identifying and implementing prevention measures.
- Conducting ongoing surveillance to monitor trends in disease incidence and the impact of the vaccination program.
- Strengthening immunization science and communicating the results, such as:
  - Undertaking and promoting a wide range of scientific activities, including tracking and monitoring diseases, characterizing disease-causing pathogens, conducting disease outbreak investigations; evaluating vaccine effectiveness, impact of prevention programs, health care delivery methods and systems; and conducting social and behavioral science research.
  - Working to translate research findings into actions and recommendations and to communicate these to the appropriate audiences.
  - Providing technical, epidemiological, educational, statistical, laboratory support and scientific assistance to state and local health departments.
- Monitoring adverse events following immunization and studying the occurrence and scientific basis for adverse events following immunization.
- 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, pharmacists, 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.
- Protecting against disease outbreaks and vaccine supply disruptions through a national pediatric stockpile of recommended vaccines available for U.S. children.

**NARRATIVE BY ACTIVITY**  
**INFECTIOUS DISEASES**  
**IMMUNIZATION AND RESPIRATORY DISEASES**

- Developing and improving laboratory diagnosis of respiratory and vaccine preventable diseases. Accurate and timely detection is imperative for detection and control of respiratory and vaccine preventable disease. CDC works to improve existing tests, develop new diagnostic tests, and ensure best practices are used to diagnose respiratory and vaccine preventable diseases in partnership with state and local health departments as well as international partners.
- Using state-of-the-art laboratory methods to monitor respiratory and vaccine preventable diseases. CDC's laboratories use molecular techniques to detect critical changes in influenza viruses that might signal a pandemic or a need for a new vaccine strain. Molecular techniques are also critical components of vaccine preventable disease monitoring systems to trace patterns of spread and direct control efforts such as with polio viruses, and to monitor emergence of antibiotic resistant strains of bacteria.
- Continuing to include immunization among its most vital programs, recognizing it as a core public health activity and an excellent example of effective primary prevention as it has done since 1962, when the first national effort to improve the immunization status of children was proposed by Congress. Immunization has been cited as one of the top ten public health achievements of the 20th century. In the U.S., vaccine-preventable diseases are at or near record low levels.

Vaccines have reduced cases of many vaccine-preventable diseases by more than 97 percent from peak levels before vaccines were available, indicated by the 20<sup>th</sup> century annual morbidity baseline, saving lives as well as treatment and hospitalization costs (see table below).

INDIGENOUS CASES OF VACCINE PREVENTABLE DISEASES IN THE U.S. FINAL REPORTS FOR 2003, 2004 AND 2005					
	20 <sup>th</sup> Century Baseline Annual Morbidity <sup>1</sup>	2003 <sup>2</sup>	2004 <sup>2</sup>	2005 <sup>3</sup>	2010 Goal
Diphtheria <sup>3</sup>	175,885	0	0	0	0
Measles <sup>4</sup>	503,282	32	10	42	0
Mumps <sup>4</sup>	152,209	231	258	314	0
Pertussis <sup>5</sup>	147,271	3,719	6,850	7,347	2,000
Polio <sup>4</sup> (paralytic, wild-type)	16,316	0	0	0 <sup>9</sup>	0
Rubella <sup>4</sup>	47,745	7	7	8	0
<i>Haemophilus influenzae</i> (type b + unknown) <sup>6</sup>	20,000	259	196	226	0
Congenital Rubella Syndrome (CRS) <sup>7</sup>	823	1	0	0	0
Tetanus <sup>3</sup>	1,314	6	6	5	0

<sup>1</sup> This table compares the 20<sup>th</sup> century annual morbidity for vaccine preventable diseases with the current incidence of vaccine preventable diseases and indicates disease was much more prevalent in the pre-vaccine era. Baseline data for 20th century annual morbidity is referenced in [MMWR](#) 1999 Apr 2;48(12):243-8.

<sup>2</sup> 2003-2005 cases correspond to Healthy People 2010 and GPRA reports on progress toward targets

<sup>3</sup> Persons under 35 years of age reported 2002-2005

<sup>4</sup> All ages reported

<sup>5</sup> Children under seven years of age

<sup>6</sup> Children under five years of age

<sup>7</sup> Children under one year of age reported 2003-2005 Estimated

<sup>8</sup> 2005 final NNDSS data. [MMWR](#) 2006 Aug 18; 55(32): 880-881

<sup>9</sup> A panel of polio experts convened by CDC confirmed a case of paralytic polio on the basis of standard clinical evidence, and the case was classified as imported vaccine-associated paralytic poliomyelitis (VAPP) with onset of illness within 30 days before entry into the United States, in accordance with CDC protocol" [MMWR](#) 2006 Feb 3; 55(04):97-99.

## **RATIONALE FOR THE BUDGET**

The FY 2008 total Budget of \$3,306,934,000 for Immunization and Respiratory Diseases reflects a decrease of \$88,923,000 below the FY 2007 Continuing Resolution of \$3,395,857,000. The FY 2008 Budget of \$544,977,000 for the discretionary Immunization and Respiratory Diseases program reflects an increase of \$54,450,000 above the FY 2007 Continuing Resolution of \$490,527,000. The FY 2008 estimate of \$2,761,957,000 for the VFC program reflects a decrease of \$143,373,000 below the FY 2007 estimate of \$2,905,330,000.

### **Discretionary Immunization Program (+\$54.5 million)**

#### Pandemic Influenza (+\$54.5 million)

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

CDC will increase demand for influenza vaccine by providing funds to States and through communication activities. CDC will increase the demand for and uptake of annual influenza vaccine, particularly to accommodate high-risk populations. Increasing vaccine demand will stimulate vaccine manufacturers to produce additional vaccine, thereby increasing vaccine production capacity and helping the nation's preparedness for a pandemic

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

The U.S. laboratory system lacks sufficient capacity to analyze large quantities of viral samples of circulating strains to identify suitable vaccine candidates. There is also a lack of dedicated facilities for development and evaluation of vaccine reference strains. Increased funding in the FY 2008 President's Budget will allow CDC to increase laboratory and analytical capabilities for genetic and antigenic analysis of influenza viruses.

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

CDC and state reference laboratories have the capacity for molecular detection of H5N1 avian influenza virus and other strains with pandemic potential, but detection is not distributed widely or at levels sufficient to respond to pandemic and pre-pandemic situations. It is vital to develop, validate, and continuously update new rapid bedside detection assays with subtype specificity for use during a pandemic. The United States also requires investments in rapid test capacity for novel influenza viruses. With increased resources in the FY 2008 President's Budget, CDC will provide for the acquisition, storage, shipping, and support of a newly acquired inventory either internally or through a commercial vendor. CDC will also work with the manufacturer to work toward more stringent quality assurance and control by instituting control protocols to ensure reagents are used properly. Finally, CDC will provide incentives for the manufacturer to make reagents available when needed.

#### Vaccines for Children (\$-143.3 million)

The FY 2008 estimate reflects a decrease of \$143.3 million for the VFC program. CDC received \$40 million per year through VFC from FY 2004 through FY 2007 to create a pediatric influenza vaccine strategic reserve. CDC is evaluating whether to continue including this funding in FY 2008 and beyond. At this time, \$20 million is being funded in FY 2008 for influenza stockpile activities, a decrease of \$20 million. Additionally, funds associated with contractual support for VMBIP terminate in FY 2007, making funding for these activities unnecessary in FY 2008. For the pediatric vaccine stockpile, fewer funds are required in FY 2008 to continue stockpiling a six month national supply of all recommended vaccines. Finally, vaccine purchase funding reflects a decrease due to a decline in one-time catch-up funding for some vaccines. Funding for VFC has increased by more than \$780 million from FY 2006 to FY 2008.

## **PERFORMANCE ANALYSIS**

### PART Results

Following its PART review, the Section 317 program initiated a business improvement project to revamp the entire vaccine distribution process and enhance the efficiency and accountability of vaccine management systems. Once fully implemented, the new systems will automate and integrate vaccine ordering and management by centralizing distribution of all public purchased vaccines.

**NARRATIVE BY ACTIVITY**  
**INFECTIOUS DISEASES**  
**IMMUNIZATION AND RESPIRATORY DISEASES**

Several ongoing actions to improve performance continue within the Immunization program including program evaluation and vaccine distribution improvements. CDC has been engaged in a comprehensive evaluation and has been working with grantees to better measure outcomes and improve understanding of the criteria for allocating resources. The next phase of the evaluation will assess differences in performance, controlling for external factors that may affect performance. Efforts have ensued since PART through the evaluation and the establishment of efficiency measures and improvements to the grant process that better integrate program budget and performance.

The program is also participating in budget and performance integration efforts in accordance with CDC's agency-wide program planning, tracking and performance measurement system.

**Current Activities:**

*Influenza*

CDC builds capacity domestically and internationally to improve systems for early detection of unusual increase in influenza activity and novel influenza viruses by:

- Providing leadership to the National Pandemic Influenza Preparedness and Response Task Force.
- Enhancing current national influenza surveillance systems to enable early detection of pandemic influenza and initiation of rapid response.
- Working with Association of Public Health Laboratories and World Health Organization (WHO) on training workshops for state laboratories on the use of molecular laboratory techniques to identify H5 viruses.
- Working with the Council of State and Territorial Epidemiologists (CSTE) to train state and local epidemiologists in response to a pandemic and strengthen public health surveillance during a pandemic.
- Working closely with WHO and National Institutes of Health (NIH) on developing and safety testing of vaccine candidates and development of additional vaccine virus seed candidates for H5N1 and other subtypes of influenza A viruses.
- Conducting worldwide monitoring of influenza viruses to collect data that contribute to annual vaccine decisions domestically and globally.
- Working with WHO to investigate influenza H5N1 among humans and provide assistance in the development of epidemiological and laboratory diagnostics capacity and training to international health authorities.
- Planning, developing and implementing laboratory and epidemiologic training in collaboration with the Global AIDS Program to enhance countries' ability to detect H5N1, especially in Africa.
- Providing funding and training to support development of pandemic planning, influenza diagnosis and surveillance capacities, and rapid response teams in developing countries.

*Immunization*

CDC supports the immunization efforts of states by providing funding for vaccine purchase and operations/infrastructure activities.

- Vaccine grants support the purchase of ACIP recommended vaccines through CDC's consolidated vaccine purchase contracts available to state and local health departments.
- According to the Institute of Medicine's "Calling the Shots" Report, operations funding is vital to the integration of new vaccines into routine medical care for everyone, increasing vaccination coverage rates, and decreasing racial and ethnic disparities.
- Operations funds support front-line public health professionals, including nurses who administer vaccines; professionals who work with immunization providers to improve their immunization practices and their handling of vaccines; and managers who coordinate and direct the complex activities needed to assure vaccination of a population.
- Operations funds pay for syringes and other equipment needed to vaccinate as well as immunization information systems that track the vaccination status of individuals.

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- Operations funds support surveillance systems that monitor the occurrence of vaccine preventable diseases at the state and local level. Surveillance of vaccine-preventable diseases also helps detection and facilitates a more rapid response to outbreaks and other changes in disease incidence.
- Operations funds also support education and outreach activities, such as educational campaigns, public and private provider education and quality assurance reviews.

In 2005 and 2006, CDC implemented an unprecedented number of expanded recommendations for children, adolescents and adults. Listed in the order in which they were recommended, new vaccines and/or expanded recommendations include:

- Use of meningococcal vaccine (MCV4) for adolescents and college freshmen to protect against meningococcal disease in adolescence and young adulthood.
- Replacement of the Td booster with the more comprehensive tetanus, diphtheria, and pertussis (Tdap) vaccine to reduce the number of cases of pertussis (whooping cough) in infants, adolescents and adults.
- Universal use of hepatitis A vaccine and lowering the age indication for vaccine to 12 months of age. Previously, the hepatitis A vaccine was recommended for use in only certain high risk groups and children living in states, communities or counties with high annual incidence of hepatitis A during 1987-1997.
- Use of the combination measles, mumps, rubella, and varicella (MMRV) vaccine to protect children aged 1 to 12 years against these four preventable diseases.
- Use of a single dose of Tdap (instead of Td) in adults 19 to 64 years of age to reduce pertussis among adults and reduce transmission of pertussis to infants.
- Use of vaccine to protect against rotavirus, a viral infection that can cause severe diarrhea, vomiting, fever and dehydration (gastroenteritis) in infants and young children.
- Expansion of routine recommendation of influenza vaccination to include all children 6 to 59 months of age.
- Recommendation of Tdap for health care workers, with an encouragement to receive the Tdap dose at an interval as short as two years from the last dose of Td.
- Routine recommendation of vaccination of girls 11 to 12 years of age against HPV, the most common sexually transmitted infection in the U.S. and the cause of most cervical cancers. Catch-up recommendation is recommended for all females up to 26 years of age.
- A second dose of varicella (chickenpox) vaccine to offer more protection to children, adolescents, and adults.
- A single dose of zoster vaccine to protect adults 60 years of age and older from the risk of herpes zoster (shingles), which symptoms can include prolonged debilitating pain.
- A second dose of MMR or mumps vaccine for health care workers

CDC promotes and facilitates the use of evidence-based immunization strategies that have been scientifically proven to sustain and raise vaccination coverage levels such as:

- Developing and using state-based immunization information systems to help identify high-risk and under-immunized populations.
- Using reminder and recall systems to improve immunization levels in children, adolescents, and adults.
- Developing software tools to assess immunization coverage in health care settings and increase immunization coverage rates.

CDC conducts prevention activities through cooperative agreements, contracts, in-house research, technical assistance and consultation, as well as planning and evaluation in cooperation with states and local agencies. Prevention activities include:

- Evaluating program performance by measuring vaccination coverage at the national, state, and urban grantee levels.

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- Conducting operational research to develop new and improved immunization delivery strategies to raise or sustain coverage levels.
- Conducting surveillance of vaccine-preventable and respiratory infectious diseases to detect and respond more rapidly to outbreaks and other changes in disease incidence.
- Providing laboratory support, training, and technical assistance to state health departments.
- 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.
- Conducting ongoing immunization safety surveillance activities and studying the occurrence and scientific basis for infrequent adverse events following vaccination.

***Best Practices***

CDC is improving the vaccine purchase and distribution process by leveraging commercial best practices to address all aspects of vaccine procurement, ordering, distribution and management and achieve cost savings and efficiencies.

- The Vaccine Management Business Improvement Project (VMBIP) is a comprehensive review and update of the public pediatric vaccine supply chain from the distribution of vaccine by the manufacturer to the point of administration (either public clinic or private provider's office).
  - CDC awarded a national centralized vaccine distribution contract in fall 2006 and will begin pilot testing the model in February 2007. Centralized distribution will result in streamlined inventories and increased efficiencies in the distribution of federally purchased vaccines. Centralized distribution will also increase the visibility of the vaccine supply, enhancing CDC's ability to address public health emergencies such as vaccine shortages.
  - CDC is maintaining a contractual mechanism for the consolidated purchase of vaccine for states and local agencies with their own funds as well as federal funds provided through grants.
- CDC maintains a stockpiled supply of recommended childhood vaccines for use in case of supply disruptions or outbreaks of vaccine-preventable diseases. Since its inception in 1983, the pediatric vaccine stockpile has been accessed more than twelve times.

***Vaccine Safety***

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

- Managing the Vaccine Adverse Event Reporting System (VAERS), in collaboration with the FDA. VAERS serves as an early warning system to detect problems that may be related to vaccines.
- Supporting the Vaccine Safety Datalink (VSD) Project, a collaborative effort involving CDC and several large managed care organizations (MCOs). The VSD was established primarily to assess immunization safety issues in the U.S. through a large-linked database (LLD) that utilizes administrative data sources at each MCO. Each participating site gathers information regarding the vaccination and medical records of millions of children and adults. Collectively, the data from VSD studies are derived from participating MCOs that contain more than nine million members, of which the VSD Project collects comprehensive medical information for more than 5.5 million people annually. The VSD enables population-based immunization safety research studies to compare the incidence of health problems between vaccinated and unvaccinated people.
- Providing in depth, standardized clinical evaluations for individuals with unusual or severe vaccine adverse events through the Clinical Immunization Safety Assessment (CISA) Network.
- Developing case definitions for adverse events following immunization through the support of the Brighton Collaboration, an international voluntary collaborative effort.

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- Promoting safer, simpler, and swifter vaccine delivery technologies to overcome potential dangers and drawbacks of using needle-syringe to administer vaccine through the Vaccine Technology Development (VAXDEV) activity.
- Establishing an extramural research activity for immunization safety. This program will support investigator-initiated, peer-reviewed research conducted by external researchers to better understand risk factors for serious adverse events following immunization. Potential areas of study include genetics involved in serious adverse events following routine immunizations, and/or the genetics involved with the failure to mount a normal immune response.
- The CISA Network collaborates with six academic centers to investigate pathophysiologic mechanisms and biologic risks of adverse events following immunization. CISA began enrolling subjects in the newly established centralized registry of clinical data and repository of biological specimens, which will be important in increasing our understanding of virologic, immunologic and genetic markers for post-vaccination adverse events.

Significant Accomplishments:

- The nation's childhood immunization coverage rates are at record high levels for most vaccines and for all the vaccination series measures. As childhood immunization coverage rates increase, cases of vaccine preventable diseases decline significantly.

VACCINATION COVERAGE LEVELS AMONG CHILDREN AGED 19–35 MONTHS, NATIONAL IMMUNIZATION SURVEY, U.S.								
Vaccine/ Dose	1999 (%)	2000 (%)	2001 (%)	2002 (%)	2003 (%)	2004 (%)	2005 (%)	2010 Goal
DTP 4 <sup>1+</sup>	83	82	82	82/95	85/96	86	86	90
Polio 3+	90	90	89	90	92	92	92	90
Hib 3+	94	93	93	93	94	94	94	90
MMR 1+	92	91	91	92	93	93	92	90
Hepatitis B 3+	88	90	89	90	92	92	93	90
Varicella	58	68	76	81	85	88	88	90

<sup>1</sup> In 2002 and 2003, CDC temporarily modified reporting on DTaP from four doses to three doses because vaccine shortages limited the availability of the fourth dose.

Other significant accomplishments include the following:

- Addressed the expanded influenza epidemiology, laboratory and extramural responsibilities through the establishment of a new Influenza Division.
- Advanced development of a rapid influenza diagnostic test, exercised organizational preparedness, and convened experts to improve influenza surveillance strategies.
- Placed staff in strategic overseas positions to coordinate avian influenza activities and provide ongoing technical assistance to improve international pandemic preparedness.
- Developed the first H5N1 Clade 2 pandemic influenza vaccine candidate for distribution to vaccine manufacturers.
- Collaborated with other partners within and outside of CDC to identify and promote health behaviors (e.g., hand hygiene, cough etiquette, and respiratory hygiene) that can prevent the spread of influenza and other respiratory infections.
- Provided onsite outbreak assistance, technical assistance and/or training to China, Vietnam, Thailand, Indonesia, Nigeria, Turkey, Brazil, Laos, Cambodia, Ukraine, Kenya, Uganda, Kazakhstan, Egypt, Djibouti, and Romania for the avian influenza outbreaks.
- Offered technical assistance through training held at CDC and regionally for many countries affiliated with the Western Pacific Regional Office and the South East Asia Regional Office of WHO
- Developed training materials for deployment of international and national rapid response teams early in a pandemic. These materials have been used in courses worldwide to train more than 500 epidemiologists, with additional courses planned in 2007.

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- Announced the first annual National Influenza Vaccination Week during the week of November 27th to December 3rd, 2006 – in conjunction with the Department of Health and Human Services, the National Influenza Vaccine Summit, partners, and stakeholders – to help raise awareness of influenza vaccination recommendations and the importance of continuing vaccination efforts throughout November and beyond.
- Documented an ongoing, dramatic effect of PCV vaccination on disease in children less than 5 years of age and on unvaccinated adults by decreasing spread from children through CDC's Emerging Infections Program's Active Bacterial Core Surveillance for invasive pneumococcal disease.
  - CDC demonstrated that PCV vaccine is reducing the disparity in disease burden between whites and blacks in the U.S.
  - CDC data from the first five years of vaccine use in the United States shows that the cost effectiveness of the childhood vaccine is more favorable than anticipated before the vaccine was licensed, because the effects on protection among the adult nonvaccinated population has been substantial.
  - Original estimates indicated only 38,000 cases would be averted at the cost of \$112,000 per life year saved. Now we know that an estimated 109,000 cases of invasive pneumococcal disease were averted through vaccination in the first five years at a cost of only \$7,500 per life year saved. The cases averted occurred not only among those vaccinated but also among the nonvaccinated.
- Documented, according to 2005 National Immunization Survey data, that there is no statistically significant difference in vaccination coverage rates between black and white children nationwide, although pockets of low coverage and disparities for individual vaccines continue to exist. Continued vigilance is needed in monitoring for disparities, identifying causes of disparities where they exist, and developing and evaluating strategies to eliminate disparities.
- Investigated the largest outbreak of mumps in the U.S. in more than a decade in conjunction with state and local health departments, with over 6,000 reported cases in 2006. CDC/HHS coordinated surveillance activities and field investigations, served as the national reference laboratory for mumps laboratory diagnosis, and provided expert technical assistance to develop and implement prevention and control activities, including revising policy recommendations for prevention and control of mumps in the United States. Because of high vaccination coverage rates in the affected states, the attack rate from this outbreak remained low. As part of the public health response, over 25,000 doses of MMR vaccine were released for outbreak control from the pediatric vaccine stockpile.
- Evaluated the economic impact of seven vaccines (DTaP, Td, Hib, polio, MMR, hepatitis B, and varicella) routinely given as part of the childhood immunization schedule and found that vaccines are tremendously cost effective. Routine childhood vaccination with these seven vaccines, which prevent nearly 14 million cases of disease and over 33,000 deaths over the lifetime of children born in any given year, resulted in annual cost saving of \$9.9 billion in direct medical cost and an additional \$33.4 billion in indirect cost savings. This study in the Archive of Pediatrics and Adolescent Medicine is the first time the seven vaccine series has been examined together with a common methodology.
- Documented elimination of the rubella virus in the U.S. Once a common disease in this country, rubella is now a rare threat. This remarkable achievement is a tribute to having a safe and effective vaccine and a successful immunization program. In spite of the remarkable achievement, the U.S. should continue its current efforts and vigilance against rubella and Congenital Rubella Syndrome to ensure that elimination of rubella is maintained.
- Assisted in the investigation of more than 100 outbreaks of gastroenteritis in 31 states, the District of Columbia, and on cruise ships in 2006; the majority of these outbreaks were linked to noroviruses.
  - Viral gastroenteritis associated with contaminated food and water affects millions of Americans each year and can have serious consequences for children, the elderly and immunocompromised persons. Despite the large public health impact, these infections remain largely undiagnosed because of a lack of routine clinical testing.

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- Noroviruses (previously called Norwalk-like viruses) are the most common cause of infectious gastroenteritis in the United States; data indicate that approximately 50% of all foodborne outbreaks are caused by noroviruses. Although traditionally these viruses have been difficult to identify, new technologies (pioneered by CDC) have been developed and made available to almost all state health departments, enabling rapid diagnosis and use of molecular tools to help identify transmission patterns during large outbreaks.
- In response to the influenza vaccine shortfall and resulting prioritization of influenza vaccine in 2004-2005, the VSD conducted a rapid assessment of influenza vaccination coverage among MCO members in Northern California.
- In 2005, findings from the Vaccine Adverse Events Reporting System (VAERS) resulted in educational efforts targeted to health care providers and changes to the newly licensed MCV4 (Menactra®) vaccine's recommendations and instructions for use. CDC published three MMWR articles to inform public health professionals of this information in FY 2006 and FY 2007.
- The Brighton Collaboration is working with 71 countries to develop standardized case definitions and guidelines for vaccine adverse events. The Brighton Collaboration finalized 11 journal articles and 6 case definitions.

**OUTPUT TABLE**

OUTPUT TABLE	FY 2006 ENACTED	FY 2007 CR	FY 2008 BUDGET	FY 2008 +/ FY 2007
# of children able to be fully vaccinated with 317 funds <sup>1</sup>	223,526	218,296	213,500	(4,795)
Section 317 State Operations				
Number of grantees with full time adult/influenza coordinators	16	24	30	6
Number of grantees achieving 80% on the 4:3:1:3:3:1 series	33	41	45	4
Number of grantees with 95% of the children participating in fully operational, population-based registries	18	23	24	1
Prevention Activities				
Support clinical evaluations to study newly hypothesized or alleged vaccine related syndromes	80	80	80	0
Immunization Registries participating in safety monitoring with VAERS	17	17	17	0
CISA centers in operation	6	6	6	0
Vaccines for Children Program				
Number of doses of Tdap purchased	2,438,820	3,137,135	3,293,992	156,857
Number of doses of Rotavirus purchased <sup>2</sup>	1,112,310	3,327,316	3,493,682	166,366

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OUTPUT TABLE	FY 2006 ENACTED	FY 2007 CR	FY 2008 BUDGET	FY 2008 +/- FY 2007
Influenza				
Number of reporting domestic sentinel physician sites to improve influenza surveillance	1,300	1,300	1,300	0
Number of state/local health departments supported to build epidemiological and lab capacity for influenza	47	47	47	0

<sup>1</sup> The reduction in this output reflects an increase in the vaccine recommendations to include a second dose of varicella, rotavirus, and expanded recommendations for influenza as well as anticipated price increases.

<sup>2</sup> Rotavirus was licensed, recommended, and funded for part of FY 2006.

### FUNCTIONAL TABLE

Immunization and Respiratory Disease Budget by Functional Activity (Dollars in Thousands)	FY 2006 Actual	FY 2007 CR	FY 2008 Budget	FY 2008 +/- FY2007
317 Immunization Program Vaccine Purchase Grants State Operations/Infrastructure Grants	\$454,489 \$261,656 \$192,833	\$425,123 \$232,158 \$192,965	\$425,123 \$232,158 \$192,965	\$0 \$0 \$0
Program Operations Pandemic Influenza	\$62,710 \$2,659	\$62,743 \$2,661	\$82,543 \$37,311	\$19,800 \$34,650
<b>Total</b>	<b>\$519,858</b>	<b>\$490,527</b>	<b>\$544,977</b>	<b>\$54,450</b>

## HIV/AIDS, VIRAL HEPATITIS, STD, AND TB PREVENTION

### AUTHORIZING LEGISLATION

PHSA §§ 301, 301(a), 301(d), 306, 307, 308(d), 310, 311, 317, 317(a), 317E, 317P, 318, 318A, 318B, 322, 325, 327, 352, 1102, 2315, 2317, 2320, 2341, 2500-2514, 2521-2524, 2625, Provisions Concerning Pregnancy and Perinatal Transmission of HIV [2625(c)], Tuskegee Health Benefits: P.L. 103-333 Ryan White CARE Act Amendments: § 502 of P.L. 106-345 International authorities: P.L. 109-149 sec. 215

HIV/AIDS, Viral Hepatitis, STD and TB Prevention (Dollars in Thousands)	FY 2006 Actual	FY 2007 CR	FY 2008 Budget	FY 2008 +/- FY 2007
BA	\$963,133	\$963,798	\$1,056,798	\$93,000

### STATEMENT OF THE BUDGET

The FY 2008 Budget of \$1,056,798,000 for HIV/AIDS, Viral Hepatitis, STD, and TB prevention reflects an increase of \$93,000,000 above the FY 2007 Continuing Resolution of \$963,798,000.

### PROGRAM DESCRIPTION

Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS), viral hepatitis, 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. Despite the availability of cost-effective interventions, these diseases continue to take a substantial toll on the health of Americans, particularly communities of color.

More than one million Americans are infected with HIV, the virus that causes AIDS, each with an estimated lifetime cost (direct and indirect) of about \$1,000,000 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.

Hepatitis B and C virus infections are common causes of liver cancer in the U.S. and globally. Hepatitis C virus (HCV) infection is the most common chronic bloodborne viral infection in the U.S. and the most common cause of liver cancer. Approximately 3.2 million Americans are currently infected with HCV. While effective childhood vaccination programs have led to dramatic (>95%) declines in new hepatitis B virus (HBV) infections among children and adolescents, many adults are still at risk. Over 50,000 new HBV infections occur among adults in the U.S. each year.

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

TB afflicted over 14,000 Americans in 2005 and is a leading infectious cause of death worldwide, killing more than two million people in 2004, despite the availability of effective treatments and control programs.

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

While effective medications are available to treat or prevent many of these diseases including syphilis, gonorrhea, chlamydia and tuberculosis, many infections are undiagnosed and untreated.

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Further, drug resistant strains from improperly treated infections are a constant threat. One example of this is the emergence of a virtually untreatable form of tuberculosis with over a 90% fatality rate. Increasing gonorrheal resistance to fluoroquinolone antibiotics, until recently a widely recommended treatment, is a growing global problem. Data from 2005 suggest that quinolone-resistant *N. gonorrhoeae* (QRNG) strains are now widespread enough in the U.S. that fluoroquinolones cannot be recommended in any population for the treatment of gonorrhea, and CDC is currently revising its treatment guidelines to reflect those results. The loss of this class of antibiotics for treatment of gonorrhea leaves only a single class of antibiotics (cephalosporins) for effective treatment. These examples underscore the importance of effective surveillance to detect resistance and control programs to prevent the emergence of drug resistant forms.

Although these diseases affect all Americans, they often hit hardest those populations that are least able to respond – the poor, minorities, youth, immigrants, incarcerated persons, and other disenfranchised populations. Syphilis and gonorrhea are examples of racial disparities in health, with blacks suffering at rates five to 18 times higher than whites. The highest chlamydia and gonorrhea rates occur among adolescents and young adults. The HIV epidemic continues to have a disproportionate impact on racial and ethnic minorities with highest rates occurring among African-Americans and Latinos. Studies of incarcerated persons have found this group is often disproportionately impacted by a variety of health problems, including HIV, viral hepatitis, STDs and TB.

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

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

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

To prevent STDs, CDC provides national leadership through research, surveillance, policy development, and assistance to states, territories, and local health departments in the delivery of services to prevent and control transmission and related complications of STDs. Comprehensive STD Prevention Systems (CSPS) grants provide federal support for a community-wide, science-based, interdisciplinary systems approach to STD prevention as recommended by the Institute of Medicine (IOM) in its report, *The Hidden Epidemic: Confronting Sexually Transmitted Diseases*. National surveillance of syphilis, chlamydia, and gonorrhea is supported and special surveillance studies are conducted for human papillomavirus (HPV), herpes simplex 2 (HSV-2), lymphogranuloma venereum (LGV), and antimicrobial susceptibilities of strains of gonorrohea. CDC conducts prevention research to improve methods and delivery of prevention services and to develop and refine interventions.

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

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CDC conducts surveillance, research and policy development to control viral hepatitis in the U.S., with activities focusing on hepatitis A virus (HAV), HBV, and HCV. The availability of effective vaccines for hepatitis A and B have enabled great progress in the control of these two infections, with a 78% reduction in acute hepatitis B infections in the U.S. since 1990. CDC has issued recommendations to eliminate hepatitis B in the United States, as well as guidelines for prevention and control of HAV and HCV.

### **RATIONALE FOR THE BUDGET**

The FY 2008 Budget of \$1,056,798,000 for HIV/AIDS, Viral Hepatitis, STD, and TB prevention reflects an increase of \$93,000,000 above the FY 2007 Continuing Resolution of \$963,798,000.

#### **HIV/AIDS Testing (+\$63 million)**

Today more than 1 million Americans are living with HIV, half of whom are African American and 17% of whom are Hispanic. One in four of those living with HIV are unaware of their infection. Without such knowledge, infected persons are unable to take advantage of treatments to preserve their lives. For example, in each of the last 3 years, 40% of those who tested positive for HIV had developed AIDS within less than 1 year. Persons who know they are infected are far more likely to take steps to protect their health and avoid transmitting HIV to their partners. In fact, studies have shown that most new HIV infections in the U.S. are transmitted by persons who are unaware of their status.

The FY 2008 budget request includes funding to increase the proportion of those who are aware of their infection, with a focus on populations, jurisdictions and venues with the highest prevalence of disease. An increase of \$63 million is requested in 2008 to support testing programs primarily in 10 jurisdictions with the greatest rates of new infections, as well as focusing on incarcerated persons and injecting drug users. CDC estimates that over 2 million Americans, mostly African-Americans, will be tested and over 31,000 new infections will be diagnosed. Additionally, the 40% of those diagnosed who would have progressed to AIDS within a year will learn of their infection earlier as a result of this initiative. They will have the opportunity to stay in better health longer, resulting in decreased overall cost to the health care system. Early diagnosis will enable these individuals to substantially alter their behavior to prevent the spread of new infections. Finally, because those who are aware of their infection are less likely to transmit the virus, this effort is expected to avert 1,500 infections in the first year alone, thereby saving \$1.5 billion in annualized medical care and lost productivity costs.

#### **Early Diagnosis Grant Program (+\$30 million)**

An additional \$30 million is requested to implement the Early Diagnosis Grant Program authorized in the Ryan White HIV/AIDS Treatment Modernization Act of 2006 (PL 109-415). The statute requires CDC to designate \$20 million of its HIV prevention funds for States with policies supporting voluntary opt out testing of pregnant women and requiring universal testing of infants. It also requires CDC to designate \$10 million for states with policies in effect supporting voluntary opt-out testing for clients at STD clinics and drug treatment centers.

### **PERFORMANCE ANALYSIS**

#### **PART Results**

Following its PART review in 2002, the Domestic HIV/AIDS Prevention program developed a process and template for the analysis of project reports received from state health departments, CBOs and capacity building assistance providers. The program is implementing the Program Evaluation and Monitoring System (PEMS). PEMS will allow CDC to utilize quantitative program data to show program effectiveness, as well as tie performance to management. Additionally, the program continues to improve its performance by measuring efficiencies and cost effectiveness, and providing technical assistance. CDC recently developed a cost model and is currently in the process of refining a resource allocation model. The resource allocation model will assist the agency in the optimal allocation of prevention dollars by CDC and its grantees to maximize the number of HIV infections prevented. The first phase of the resource allocation model task order has been completed and CDC is currently conducting a variety of analyses to evaluate the sensitivity of the model.

Based on PART recommendations from STD and TB's 2004 review, CDC's TB program instituted a new funding formula for determining cooperative agreement awards. This formula utilized an analysis of the burden of disease in a given state to determine funding for the FY 2005 funding cycle. Phase II of the formula will be implemented in FY 2008. Additionally, the STD and TB programs are working to develop sufficient evaluations to analyze program performance. The evaluation process is ongoing and new projects

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will be funded in FY 2007 pending available resources. Resources for syphilis elimination were also realigned within existing high morbidity areas to reflect epidemiology; in this evaluation a new high morbidity area was added. Cost analyses are currently being developed and will be implemented pending approvals. The program has also developed new long-term annual performance measures which will track the overall effectiveness of projects. Development of a project tracking system is currently underway.

All four programs (HIV/AIDS, viral hepatitis, STD and TB) are also participating in budget and performance integration efforts in accordance with CDC's agency-wide program planning, tracking and performance measurement system.

**Current Activities**

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

- HIV/AIDS Surveillance – CDC and state and local health departments use surveillance to track the epidemic and understand its dynamics. Surveillance provides demographic, laboratory, clinical, and behavioral data that are used to identify populations at greatest risk for HIV infection. These data also help CDC estimate the size and scope of the national epidemic. CDC provides funding and technical assistance to 65 state and local health departments to conduct HIV/AIDS case surveillance. CDC recommends that all states and territories conduct HIV surveillance using a confidential, name-based system. As of December 2006, 51 areas (46 states and five territories) were conducting HIV surveillance using confidential name-based methods. CDC supports projects in 34 areas to assess HIV incidence in conjunction with HIV case reporting. To better understand the dynamics of the epidemic, CDC also conducts specialized surveys of infected and high-risk persons.
- HIV Research – CDC conducts biomedical and behavioral research to better understand the complex factors that lead to HIV infection and to identify effective approaches to prevent infection. Priorities for HIV research include research related to diagnostic tests, microbicides, vaccines, and behavioral research focused on eliminating disparities. For example, prior to the approval of the OraQuick HIV rapid test, CDC was involved in studies of the test's accuracy as well as how the test could be used in certain settings. Most recently, CDC has initiated trials of the safety and efficacy of the prophylactic use of anti-retroviral medications for use in preventing HIV infection.
- HIV Interventions – Early in the epidemic, CDC recognized that the involvement of affected communities was a critical success factor in HIV/AIDS prevention programs. CDC uses several tools to involve communities in HIV prevention, including community planning and direct funding of CBOs. Through the HIV community planning process, which is supported by CDC funding, communities tailor HIV prevention programs to address local needs. Since 1989, CDC has provided funding directly to CBOs to conduct HIV prevention activities. Since 1999, CDC has received additional funding through the Minority AIDS Initiative to augment these existing efforts to address racial and ethnic disparities in HIV/AIDS.
- Capacity-Building – Underpinning intervention programs are capacity-building efforts. To build the capacity of its state and CBO partners to prevent HIV, CDC: (1) supports national meetings and satellite broadcasts as a forum for sharing new ideas and best practices; (2) funds nongovernmental organizations to provide training and materials; (3) provides direct technical assistance to CBOs; and (4) synthesizes and disseminates information on science-based interventions.
- Evaluation – CDC works to evaluate its programs in order to monitor progress and refine efforts. PEMS has been developed by CDC to collect common data elements on HIV prevention activities to monitor progress on core performance indicators. Through PEMS, CDC aims to improve quality and analysis of data to monitor HIV programs. Counseling, testing and referral data from PEMS will be the first available data from the system and are expected in early 2007.

STD Prevention Activities – CDC's activities include STD-related infertility prevention, syphilis elimination, and clinical, epidemiologic, behavioral, laboratory and health services research.

- Infertility Prevention Program – CDC and the HHS Office of Population Affairs (OPA) work with family planning, STD, and primary health care programs to implement infertility prevention activities for uninsured and underinsured women, primarily screening for chlamydia and gonorrhea. CDC also conducts research to identify the biological and behavioral determinants of chlamydia transmission and assess the feasibility, acceptability, and cost-effectiveness of chlamydia screening for males. CDC supports screening programs in all 65 STD project areas.

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- Syphilis Elimination – In 1999, CDC launched its National Plan to Eliminate Syphilis from the U.S. to capitalize on a decade of declining rates of syphilis. The plan was designed to end the sustained transmission of the disease in the U.S. by focusing efforts on the populations most affected by syphilis – heterosexual minority populations, particularly African Americans. In these populations, substantial progress has been made in reducing the burden of syphilis, yet overall syphilis rates have been on the rise, largely because of increasing rates of syphilis among men who have sex with men (MSM). During 2005, CDC reviewed its national syphilis plan to assess current efforts and develop new strategies to further reduce syphilis in the U.S. CDC's updated Syphilis Elimination Plan, Together We Can: The National Plan to Eliminate Syphilis from the United States, is designed to sustain elimination efforts in populations traditionally at risk and to support innovative solutions to the resurgence of syphilis among MSM.
- HPV and other STDs – CDC also supports sentinel surveillance, formative communications research, behavioral research, and provider surveys on HPV, as well as work developing recommendations for HPV vaccines and implementation issues pertinent to such vaccines, such as systems to monitor disease outcomes. In addition, CDC supports special surveillance studies for HPV and HSV-2; epidemiologic, behavioral, laboratory and health services research on a variety of STDs; and program support, training and health communications for STD prevention programs nationally.

TB Elimination Activities – CDC supports state control programs, clinical and epidemiologic research, laboratory services and global partnership.

- State TB Control programs – CDC funds 68 cooperative agreements with state and local health departments for TB prevention and control, including technical and financial assistance, laboratory support, model centers, and healthcare worker training. CDC works with 41 state and local TB advisory committees that represent patients and providers.
- Applied Clinical and Epidemiologic TB Research – CDC collaborates, through contracts and interagency agreements, with the Veterans Administration and other partners, to maintain a consortium for TB clinical trials research. CDC also supports the Tuberculosis Epidemiologic Studies Consortium to strengthen TB epidemiological, behavioral, economic, laboratory, and operational research capacity within states, cities, and academic institutions.
- Works with a global partnership to implement the World Health Organization's "Stop TB" Initiative.
- TB Control along the U.S.-Mexico Border – CDC, in collaboration with international partners, piloted the Binational TB Card in three U.S. states and five Mexican states to ensure continuity of care and completion of TB treatment for patients who migrate between the U.S. and Mexico; to coordinate the referral of patients between the health systems of both countries; and to prevent multi-drug resistant strains of TB. Preliminary results of the Binational TB Card are promising. CDC has disseminated this program and its results for states and others to support.

Hepatitis Control Activities – CDC works to prevent viral hepatitis infections and their acute and chronic liver disease consequences.

- Educating health care and public health professionals to improve identification of persons at risk for chronic HCV infection as well as ensuring appropriate counseling, diagnosis, management, and treatment.
- Conducting national surveillance for chronic HBV and HCV infections, continuing to evaluate current routine nationwide surveillance activities, and implementing enhanced surveillance in selected states and counties. The goal of surveillance is to monitor who is getting infected with HBV and HCV to ensure appropriate counseling, testing, and medical management of infected persons.

**Significant Accomplishments**

- Began to implement the President's Initiative to Continue the Fight Against HIV/AIDS in America. With funding requested in the FY 2007 and 2008 President's Budgets, CDC will work to facilitate the testing of more than 3 million Americans. Funds will expand the use of HIV rapid testing in health care settings, non-clinical settings and correctional facilities. Funds will also support testing of injection drug users and the creation of new testing guidelines, models, and best practices.

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- Issued Revised Recommendations for HIV Testing Adults, Adolescents, and Pregnant Women in Health-Care Settings, designed to increase the proportion of Americans who are aware of their HIV status. Supported this release with podcasts, satellite broadcasts, and meetings with policy-makers and providers. One quarter of HIV-infected Americans are unaware of their infection. Additionally, about 40% of those who are diagnosed with HIV receive an AIDS diagnosis less than a year later. This reveals missed opportunities to prevent transmission and protect the health of those who are infected. Several major insurers have announced their willingness to cover recommended HIV testing for their insured populations.
- Issued Comprehensive Risk Counseling and Services (CRCS) Implementation Manual to provide day-to-day guidance and assistance for implementing CRCS interventions. It can also be used as a general guide to planning CRCS services and developing agency's CRCS protocols. Prevention case management is now called CRCS; CDC made this change in order to reduce confusion among providers and clients regarding differences between CRCS and other case management systems.
- Published "Best-Evidence Interventions: Findings from a Systematic Review of HIV Behavioral Interventions for U.S. Populations at High Risk, 2000-2004," in the January 2007 issue of the American Journal of Public Health. The project evaluated information from 100 studies published between 2000 and 2004 that tested the efficacy of behavioral HIV prevention interventions. A total of 18 new interventions serving a range of populations at risk for acquiring or transmitting HIV infection met the criteria for best evidence of efficacy. These findings will be disseminated to prevention programs across the nation.
- Continued to publish HIV/AIDS surveillance data which is used across the federal government and by other organizations to guide HIV-related programs, including those of CDC, the Health Resources and Services Administration (HRSA) and the Department of Housing and Urban Development (HUD). In July 2005, CDC formally recommended confidential, name-based HIV surveillance to all states and territories. In 2005, trend data from 35 areas (33 states, Guam, and the U.S. Virgin Islands) were reported, representing nearly two-thirds of the national HIV burden and providing a more accurate picture of the epidemic in the U.S.
- The number of children nationwide reported to have acquired AIDS perinatally declined to an estimated 58 in 2005, down from an estimated 247 in 1998.
- Between 1988 and 2005, screening programs in HHS Region X have demonstrated a decline in chlamydia positivity of 49 percent (from 15.1 percent to 7.4 percent) among 15 to 24 year old women in participating family planning clinics.
- Conducted a study with Kaiser Permanente demonstrating the feasibility and cost-effectiveness of chlamydia screening in young women in managed care settings.
- Reduced the reported rate of primary and secondary syphilis among females 55 percent from 2.0 cases per 100,000 population in 1999 to 0.9 cases per 100,000 population in 2005.
- Reduced the reported rate of congenital syphilis 45 percent from 14.6 cases per 100,000 live births in 1999 to 8.0 cases per 100,000 live births in 2005.
- Decreased black: white syphilis reported ratio from 43:1 in 1997 to 5.4:1 in 2005.
- Published Together We Can: The National Plan to Eliminate Syphilis from the U.S. and began implementation of new strategies in the plan to support national, state and local syphilis elimination efforts.
- Published revised STD Prevention Treatment Guidelines, the most widely referenced and authoritative source on STD treatment and management in the world.
- Developed and disseminated HPV educational materials for health care providers, patients, and the general public. Developed HPV vaccine recommendations. Launched a comprehensive HPV website and conducted a national Webcast targeted to health care providers.
- Published an alert regarding the emergence of extensively-drug-resistant TB (XDR TB). Collaborated with national and international health agencies to provide leadership, technical support and capacity building to ensure that proper action is taken to limit the development and spread of XDR TB.

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- Achieved the lowest recorded rate of TB (4.8 per 100,000 persons) since reporting began in 1953. The rate among U.S. born persons declined most dramatically – 66.3 percent from 1993. The rate among persons born outside the U.S. declined 36 percent since 1993. Overall, a total of 14,093 cases were reported in 2005.
- Issued guidelines to improve TB control in the U.S. in three critical areas: the use of new diagnostic tools, investigating contacts of TB cases, and preventing infection among health care workers, patients and their families.
- Published recommendations for TB elimination in low-incidence areas, and recommendations for TB prevention and control among homeless persons, persons in correctional facilities, persons in long-term care facilities, migrant workers and at-risk minority populations.
- Published revised recommendations for the elimination of Hepatitis B in the United States.
- Expanded CDC's National Hepatitis C Prevention Strategy by funding: hepatitis C coordinators in 52 jurisdictions, including state, territorial, and large metropolitan health departments and the Indian Health Service; state-based hepatitis C/viral hepatitis prevention plans in 24 states; five Viral Hepatitis Integration and Intervention Projects (VHIPS) to establish best practices for prevention of hepatitis C and other causes of viral hepatitis; and 12 Viral Hepatitis Education and Training Projects (VHETS) to develop and disseminate hepatitis C education and training materials.

**OUTPUT TABLE**

OUTPUT TABLE	FY 2006 ACTUAL	FY 2007 CR	FY 2008 BUDGET	FY 2008 +/- FY 2007
<b>HIV Prevention</b>				
Areas funded for HIV prevention	65	65	65	0
Areas funded for HIV/AIDS surveillance	65	65	65	0
No. of areas funded to estimate HIV incidence	34	34	34	0
No. of cities to conduct surveillance for behavioral risks for HIV infection in high-risk groups	24	24	24	0
No. of capacity building assistance providers supporting minority CBOs	31	31	31	0
Number of CBOs funded to support community level interventions <sup>1</sup>	162	162	162	0
No. of cities funded with enhanced testing activities	0	0	10	10
Minority postdoctoral fellowships	3	3	3	0
<b>STD Prevention</b>				
Technical and financial assistance to grantees for STD Prevention	65	65	65	0
Syphilis Elimination Programs Funded	38	38	38	0
Regional infertility programs funded	10	10	10	0

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OUTPUT TABLE	FY 2006 ACTUAL	FY 2007 CR	FY 2008 BUDGET	
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
<b>TB Elimination</b>				
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	2	2	2	0
Number of task orders funded under the TB Epidemiologic Studies Consortia	6	3	3	0
Number of communications disseminated via CD-ROM	11,300	11,200	11,200	0
Number of state public health laboratories participating in the TB Genotyping Network	50	50	50	0
<b>Viral Hepatitis Prevention</b>				
Number of sites funded for viral hepatitis surveillance	7	7	7	0
Number of areas funded for viral hepatitis prevention activities	52	52	52	0

<sup>1</sup>Includes activities supported with HHS Minority AIDS funding.

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**FUNCTIONAL TABLE**

<b>HIV/AIDS, Viral Hepatitis, STD, &amp; TB Prevention</b>				
<b>Budget by Functional Activity</b> <b>(Dollars in Thousands)</b>	<b>FY 2006</b> <b>Actual</b>	<b>FY 2007</b> <b>CR</b>	<b>FY 2008</b> <b>Budget</b>	<b>FY 2008 +/-</b> <b>FY 2007</b>
HIV/AIDS, Research and Domestic	\$651,657	\$652,107	\$745,107	\$93,000
Viral Hepatitis	\$17,578	\$17,590	\$17,590	\$0
Sexually Transmitted Diseases (STD)	\$157,201	\$157,310	\$157,310	\$0
Tuberculosis (TB)	\$136,697	\$136,791	\$136,791	\$0
<b>Total</b>	<b>\$963,133</b>	<b>\$963,798</b>	<b>\$1,056,798</b>	<b>\$93,000</b>

**CDC-WIDE HIV FUNDING**

FY 2008 BUDGET SUBMISSION CENTERS FOR DISEASE CONTROL AND PREVENTION CDC WIDE HIV/AIDS PREVENTION (DOLLARS IN THOUSANDS)			
<b>Budget Activity</b>	<b>FY 2006</b> <b>Actual</b>	<b>FY 2007</b> <b>CR</b>	<b>FY 2008</b> <b>Budget</b>
<b>HIV, Viral Hepatitis, STD, and TB Prevention</b>			
1. State and Local Health Departments	\$405,944	\$406,224	\$499,224
2. Directly Funded Community, National, Regional and Other Organizations	\$170,449	\$170,567	\$170,567
3. CDC Research, Surveillance Analysis, Technical Assistance, and Program Support	\$75,264	\$75,316	\$75,316
<b>Subtotal, NCHHSTP</b>	<b>\$651,657</b>	<b>\$652,107</b>	<b>\$745,107</b>
<b>Global AIDS Program</b>	\$122,560	\$121,224	\$121,223
<b>Chronic Disease Prevention, Health Promotion, and Genomics</b>	\$46,717	\$46,749	\$46,749
<b>Birth Defects, Developmental Disabilities, Disability and Health</b>	\$17,291	\$17,304	\$17,304
<b>Total, CDC:</b>	<b>\$838,225</b>	<b>\$837,384</b>	<b>\$930,383</b>

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ZOONOTIC, VECTOR-BORNE, AND ENTERIC DISEASES

## ZOONOTIC, VECTOR-BORNE, AND ENTERIC DISEASES

### AUTHORIZING LEGISLATION

PHSA §§ 301, 307, 310, 311, 317, 317P, 317R, 317S, 319, 319E, 319F, 319G, 322, 327, 352, 361-363, 1102, 1182, 1222Immigration and Nationality Act; §§ 212, 213

Zoonotic, Vector Borne, and Enteric Diseases (Dollars in Thousands)	FY 2006 Actual	FY 2007 CR	FY 2008 Budget	FY 2008 +/- FY 2007
BA	\$87,797	\$79,852	\$62,952	(\$16,900)

### STATEMENT OF THE BUDGET

The FY 2008 Budget of \$62,952,000 for Zoonotic, Vector-Borne, and Enteric Diseases reflects a decrease of \$16,900,000 below the FY 2007 Continuing Resolution of \$79,852,000.

### PROGRAM DESCRIPTION

Contrary to past predictions, the threat of infectious diseases still remains. Over more, in recent decades multiple factors have come together to create a new epidemiological era characterized by increases in emerging and reemerging infectious diseases. An estimated 75% of these are zoonotic in origin-transmitted from animals to humans. In recent years, the world has had to respond to SARS--originally from bats, Sin Nombre virus and other hantaviruses from rodents, Nipah virus from bats via pigs, influenza viruses from aquatic birds and domesticated poultry, and West Nile virus from birds via mosquitoes. It is difficult to predict when and where the next event will occur. Gaining a better understanding of zoonotic disease emergence, prevention, and control requires quality basic and applied research, which results from extensive interaction and collaboration among professionals from multiple disciplines.

Diseases transmitted by vectors – insects or ticks – are especially difficult to control. Examples of vector-borne pathogens include such Class A Biodefense agents as plague, tularemia and many hemorrhagic viruses, like Rift Valley fever. Malaria remains one of the most important infectious diseases in the world. Vectors are one of the most common conduits of animal viruses to humans. Globalization, urbanization, and population growth are steadily increasing the incidence of once-exotic vector-borne diseases. Recent examples of this risk are the epidemic of chikungunya virus in the Indian Ocean, the jump of Rift Valley fever from Africa to Saudi Arabia, and outbreaks of dengue along the US-Mexican border. Effective control of vector borne diseases like dengue, malaria and Lyme disease, requires integrated, innovative research aimed at improved diagnostics, vaccines, therapy, and vector control.

CDC estimates that each year 76 million U.S. citizens suffer from foodborne illnesses; 325,000 are hospitalized, approximately 5,000 die, and the economic burden is estimated to be greater than \$6 billion. Over 1000 foodborne disease outbreaks occur each year in the U.S., each one making groups of people ill, and taking public health and food industry resources to investigate and control. Each year, CDC consults with state and local partners on more than 100 of these outbreaks. Enhanced collaborative surveillance networks are detecting outbreaks sooner, making their investigations faster, helping to identify new points of control and prevention, and providing information on the burden and source of these infections. With better surveillance information and improved prevention strategies, efforts by many partners along the food chain from farm to table have begun to have an impact. However, recent E. coli outbreaks linked to spinach and lettuce, hepatitis A outbreaks linked to green onions, and other bacterial, viral and parasitic outbreaks from a variety of foods show that more prevention efforts are needed.

Over the past century, advances in water quality have dramatically improved the public's health in the United States. However, new challenges to the nation's water quality have arisen. These include the emergence of chlorine-resistant pathogens, chemical contamination of water sources, crumbling infrastructure, increased recreational water contamination, cooling tower and other non-traditional water exposures, and increasing water re-use. An estimated four to 16 million cases of gastrointestinal illness associated with public water systems occur annually. However, these estimates are imprecise and do not include the 45 million people served by small or individual water systems, the > 60 million people swimming every year, or other water exposures. These challenges pose a unique opportunity for CDC to lead a public health effort to fill critical knowledge gaps in areas not regulated by EPA (small, unregulated drinking water systems, private wells, disinfected swimming areas) or areas under minimal oversight (building-specific problems). CDC will also

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continue to strengthen collaboration with EPA, state, and local partners to provide additional data for improved prevention efforts aimed at reducing the burden of acute and chronic waterborne disease in the United States. CDC provides national surveillance on waterborne disease outbreaks, outbreak investigation assistance, consultation and guidance on healthy use of water and operation of recreational water venues and private wells. Diseases transmitted by water are also an important health threat in the developing world, where an estimated 2 million children die each year of diseases that are often related to contaminated water. The Safe Water System is a water quality intervention that employs simple, robust, and inexpensive technologies appropriate for the developing world. CDC and partners have implemented this program in over 20 countries on five continents. CDC provides technical assistance to these country programs and studies the health impact and sustainability of the program.

CDC is bringing together similarly focused programs to provide national and international scientific and programmatic leadership for zoonotic, vector-borne, foodborne, waterborne, mycotic, and related infections to identify, investigate, diagnose, treat, and prevent these diseases. Through these related programs, CDC focuses on the continuing challenge of emerging and re-emerging zoonoses and recognizes the importance and need to work collaboratively, not just across CDC and the traditional public health community, but also with agricultural, wildlife, and companion animal agencies and organizations. CDC is partnering with other federal agencies that focus on animal health and with state governments, academic, and private institutions to explore and address these issues. CDC sponsors several projects which either utilize data from humans and animals, or that evaluate animal health as a sentinel for human health. Protecting the public's health from zoonotic diseases requires a merging of responsibilities at the interface of animal health, human health, and the environment; this preparation is leading to significant progress in CDC's ability to prepare for and respond to these threats.

### **RATIONALE FOR THE BUDGET**

The FY 2008 Budget of \$62,952,000 for Zoonotic, Vector-Borne, and Enteric Diseases reflects a decrease of \$16,900,000 below the FY 2007 Continuing Resolution of \$79,852,000.

#### West Nile Virus (-\$16.9 million)

CDC has awarded funds to 57 state, local, and territorial public health agencies to assist in the development of comprehensive, long-term disease monitoring, prevention, and control programs for WNV. WNV funding has built infrastructure and led to the enhancement of state-based programs to make states better able to prevent, detect, and respond to the threat of WNV and other vector-borne infectious diseases. The establishment of this national program has also enhanced viral laboratory capacity, veterinarian epidemiology capacity, and surveillance of disease.

A reduction of \$16.9 million will decrease the amount of funds available to state and local health departments to respond to the nationwide epidemic while making every attempt to distribute funds according to the profile of the WNV epidemic. Several years of CDC funds have allowed states to develop and enhance their WNV activities, CDC will also limit funding for extramural and intramural research.

### **PERFORMANCE ANALYSIS**

#### PART Results

A summary of FoodNet data from 1996 to 2005 published on April 14, 2006, showed significant declines in rates of infection with *E. coli* O157, Listeria, and *Campylobacter*, suggesting the current efforts to reduce these diseases are largely on track toward the Healthy People 2010 objectives. Rates of infection with *Salmonella* have only modestly decreased. This may reflect increasing *Salmonella* contamination in poultry and challenges related to fresh produce. New interagency efforts in research and interventions to improve the effectiveness of food safety measures for *Salmonella* are now underway. CDC, in collaboration with FDA, began broad implementation of a national Listeria Action Plan to further reduce Listeria cases through efficient risk management, by empowering consumers and improving consumer safety.

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**Current Activities**

- Maintaining Healthy Pets, Healthy People website that provides information about the health-related risks of owning and caring for animals.
- Providing outbreak investigation, infection control, and scientific evaluations when a new and potentially highly dangerous disease is detected anywhere in the world; the World Health Organization and foreign governments routinely call on CDC's unique capabilities in dealing with highly pathogenic and transmissible viruses requiring biosafety level four containment.
- Continuing multi-disciplinary studies aimed at developing and evaluating oral reservoir targeted vaccines for prevention of Lyme disease; evaluating current Lyme disease case definition, surveillance methods, and reporting practices; making recommendations for sustainable modifications.
- In collaboration with Colorado Health Sciences Center, evaluating an intervention program to promote prevention activities against West Nile virus disease among transplant recipients.
- Implementing in state health departments the newly developed PulseNet surveillance system for plague and tularemia, two category A bioterrorism agents that also exist in nature and can be transmitted from animals to humans by arthropod vectors. Once fully implemented, this system will enable identification of the geographic origin of strains from these two agents as well as determine the relatedness of strains isolated from persons with these infections. This system will enhance our ability to identify possible bioterrorism events, as well as more clearly define the extent and distribution of these naturally occurring pathogens.
- The PulseNet system for *Yersinia pestis* is fully developed and posted and has been utilized to link naturally occurring human cases with vector/rodent isolates. Utility evaluation of developed pulsed-field gel electrophoresis (PFGE) methods for *Francisella tularensis* is targeted for FY07.
- Continuing the major foodborne surveillance and investigative networks of FoodNet, PulseNet and OutbreakNet, providing detailed data on cases of foodborne illness, on the organisms that cause them and on the foods that are the sources of the infections. The enhanced hepatitis surveillance network has now been implemented in six of the Emerging Infectious Diseases sites that FoodNet is in. These networks provide the most comprehensive information available on cases of foodborne illness, and are central to the investigation of multi-state outbreaks of foodborne infection.
- Public health laboratories in all 50 states and the federal food regulatory agencies FDA and USDA participate in PulseNet, the network for fingerprinting bacterial foodborne pathogens. Shared data review with Canada is now routine and enhances our capacity to detect and investigate outbreaks of microbes covered by PulseNet. PulseNet networks are now beginning operations in Asia/Pacific, China, Latin America and Europe. New laboratory methods to make PulseNet faster are being evaluated in state public health laboratories and at CDC. CDC is also advancing laboratory diagnostics, developing, evaluating, and introducing new molecular fingerprinting methods and expanding surveillance networks for foodborne bacteria, viruses, parasites, and other contaminants.
- Conducting a cost/benefit analysis for screening newborns for toxoplasmosis. Preliminary analysis indicated that even with a treatment efficacy of 35% and test costs of \$7 per infant (high estimate), screening becomes cost saving at an incidence of more than 2.8/100,000 (the U.S. incidence is about 10/10,000).
- Providing assistance to clinicians and health authorities in the investigation of and response to suspected prion disease clusters and to increased concerns about possible iatrogenic transmissions.
- Expanding the national provider education program for Chronic Fatigue Syndrome, which now includes: CME-accredited courses for physicians, physician assistants, nurse practitioners, and allied health professionals; a teaching program at medical school Grand Rounds; and presentation and booth activities at medical conferences.

Significant Accomplishments

- Consulted with the Ministry of Health and the Gorgas Institute in Panama in early 2005 on an outbreak of hantavirus pulmonary syndrome in the province of Los Santos, including consultations on case definitions for the general and medical populations, medical care and diagnostic confirmation, geographic distribution of confirmed HPS cases, rodent ecology, monitoring of reservoir populations, and health education and prevention.
- Developed the world's first DNA vaccine, which was licensed for use in January 2005. The vaccine, which prevents West Nile virus in horses, is now undergoing NIH-sponsored, Phase I, human clinical trials. DNA vaccines have major advantages over traditional vaccines because they do not require cold storage, are very safe, and do not interfere with each other immunologically when administered simultaneously. Similar DNA vaccines for two major tropical diseases, yellow fever and dengue, are in advanced development.
- Developed, implemented, and maintain ArboNet, the nationwide West Nile virus surveillance system that links all 50 states to a central, daily data base that records and maps cases in humans and animals. ArboNet, developed in 2000, is the primary national tool for predicting and responding to shifting incidence of WNV.
- Enhanced national foodborne outbreak surveillance by implementing in 2006 a new national web-based reporting system with advanced data security and management functions. This system collects extensive information on 1,200 to 1,500 foodborne outbreaks annually. This system has demonstrated a 90% decrease in outbreaks due to Salmonella in eggs between 1993 and 2003, and that the proportion of outbreaks due to contaminated produce increased over the past three decades.
- Through PulseNet and with state partners, rapidly identified a nationwide outbreak of E. coli O157 from contaminated spinach, so that many potential illnesses were avoided by an early FDA recall of the product.
- Organized the Council to Improve Foodborne Outbreak Response (CIFOR), composed of nine local, state, and federal partner associations and agencies. The goal of CIFOR is to identify barriers among the components of the food safety system (disease reporting, outbreak identification and response, interventions, and regulatory activities) and to address these barriers with a variety of practical products. CIFOR is initially focused on earlier detection and faster response to foodborne disease outbreaks by developing guidelines for multi-state outbreaks, program performance indicators, and establishment of a web-based library of tools for local, state and federal staff involved in foodborne outbreak response activities.
- Continued to expand the collaborative CDC Safe Water System, now in 23 countries, empowering families in developing countries to make their drinking water safe through a variety of public and private partnerships. The SWS program in Kenya won a World Bank Award in 2006 for innovative prevention, and markets a basket of water treatment, mosquito bednets, vitamins and other simple public health interventions to those most in need.
- Strengthened the laboratory diagnosis of parasitic diseases in the United States through DPDx, a project that uses telediagnosis and provides protocols, reagents, and training for diagnostics. Through the end of FY 2005, DPDx provided funding for telediagnosis equipment to a total of 52 public health labs and telediagnosis submissions have increased 300% from FY 2000 to FY 2005. From FY 2000 to FY 2005, through training and technology transfer, the number of state health labs with the potential to use molecular techniques to detect parasites increased from zero to 20.
- Enhanced surveillance for prion diseases in the U.S. through several surveillance mechanisms including:
  - Continued support for the National Prion Disease Pathology Surveillance Center at Case Western Reserve University, as part of CDC efforts to facilitate improved recognition and diagnoses of prion diseases in the United States and to increase the number of confirmatory autopsies on patients in whom this type of disease is clinically suspected or diagnosed; and

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- Special support to state health departments, particularly to states where presence of bovine spongiform encephalopathy (BSE, commonly known as mad cow disease) has been documented, where there are large populations and many potential visitors to countries with major outbreaks of BSE, and where the presence of chronic wasting disease (CWD) in free-ranging deer and/or elk is a special concern.
- Completed baseline studies of chronic fatigue syndrome in metropolitan, urban, and rural populations of Georgia; and completed public health genomics studies involving CFS, post-infection fatigue, and interferon-alpha-associated fatigue.

**OUTPUT TABLE**

OUTPUT TABLE	FY 2006 ACTUAL	FY 2007 CR	FY 2008 BUDGET	FY 2008 +/- FY 2007
Number of national surveillance and response programs in states and large local health departments for WNV and other arboviruses	58	58	58	0
Number of countries receiving PulseNet training, protocols	11	12	12	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	58	62	62	0
Number of states and territories reporting food-borne disease data to CDC electronically	53	54	54	0

**FUNCTIONAL TABLE**

Zoonotic, Vector Borne, and Enteric Diseases		FY 2006 Actual	FY 2007 CR	FY 2008 Budget	FY 2008 +/- FY2007
<b>Budget by Functional Activity (Dollars in Thousands)</b>					
Zoonotic, Vector-Borne, and Enteric Diseases		\$54,278	\$46,310	\$29,410	(\$16,900)
Food Safety		\$28,624	\$28,644	\$28,644	\$0
Chronic Fatigue Syndrome		\$4,895	\$4,898	\$4,898	\$0
<b>Total</b>		<b>\$87,797</b>	<b>\$79,852</b>	<b>\$62,952</b>	<b>(\$16,900)</b>

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**INFECTIOUS DISEASES**  
**PREPAREDNESS, DETECTION, AND CONTROL OF INFECTIOUS DISEASES**

## **PREPAREDNESS, DETECTION, AND CONTROL OF INFECTIOUS DISEASES**

### **AUTHORIZING LEGISLATION**

PHSA §§ 301, 307, 310, 311, 317<sup>3</sup>, 317N<sup>3</sup>, 317S<sup>5</sup>, 319, 322, 325, 327, 352, 361-369, Immigration and Nationality Act §§ 212, 232

<b>Preparedness, Detection, and Control of Infectious Diseases (Dollars in Thousands)</b>	<b>FY 2006 Actual</b>	<b>FY 2007 CR</b>	<b>FY 2008 Budget</b>	<b>FY 2008 +/- FY 2007</b>
BA	\$124,368	\$124,449	\$129,641	\$5,192

### **STATEMENT OF THE BUDGET**

The FY 2008 Budget of \$129,641,000 for Preparedness, Detection, and Control of Infectious Diseases reflects an increase of \$5,192,000 above the FY 2007 Continuing Resolution of \$124,449,000.

### **PROGRAM DESCRIPTION**

CDC's activities related to preparedness, detection and control of infectious diseases protect populations domestically and internationally through leadership, partnerships, epidemiologic and laboratory studies, and the use of quality systems, standards, and practices. In carrying out its mission, CDC works collaboratively across the agency, and with the Agency's national and global partners to conduct, coordinate, and support infectious disease surveillance, research, and prevention.

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. Prevention of 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.

An Institute of Medicine (IOM) report published in March 2003, *Microbial Threats to Health: Emergence, Detection, and Response*, recognizes that while we have made dramatic advances in the prevention and control of infectious diseases, the magnitude and urgency of these problems requires renewed concern and commitment. CDC continues to work with other federal agencies, state and local health departments, universities, private industry, foreign governments, the World Health Organization (WHO), and other organizations to build public health capacity for recognizing and responding to infectious diseases and protecting the health of Americans at home and abroad.

Public health capacity includes strong CDC laboratories and specialized expertise; excellence in laboratory practices around the world; effective, standards-based surveillance; domestic and international infectious disease platforms for conducting research and implementing public health programs; and the authority to make and enforce public health regulations. A strong public health system plays a key role in ensuring preparedness for infectious disease emergencies; minimizing health disparities in the United States; preventing the introduction, transmission, and spread of communicable diseases from foreign countries; protecting patients and healthcare personnel from infectious diseases; and promoting safety, quality, and value in healthcare delivery systems.

One example of an emerging threat is antibiotic resistance, a growing concern around the world. Many important human infections are developing resistance to the antimicrobial drugs used to treat them. In the 1970s, virtually all *Streptococcus pneumoniae*, an organism which is a common cause of ear infections, meningitis, and pneumonia, were susceptible to preferred drugs. Now up to 30 percent found in some areas of the U.S. are no longer susceptible to penicillin, and multidrug resistance is common. While the new *pneumococcal* conjugate vaccine has dramatically reduced the number of *pneumococcal* infections caused by resistant strains, strains not covered by the vaccine are emerging and some are highly resistant to multiple antibiotics.

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Multidrug resistance is also a significant and growing problem in healthcare associated gram negative bacteria. For example, in 2004, data submitted to CDC indicated that 16 percent of healthcare-associated infections with an organism called *Acinetobacter* were caused by isolates that were resistant to all major classes of antimicrobial agents.

*Staphylococcus aureus* is a common cause of skin and more serious infections and over 60 percent of infections acquired in U.S. intensive care units are now resistant to the class of beta-lactam antibiotics which includes penicillins and cephalosporin antibiotics. These are referred to as methicillin-resistant *Staphylococcus aureus* (MRSA). Some infections found among hospitalized patients are resistant to virtually all effective antimicrobial drugs available. New, potentially more virulent strains of MRSA have now emerged in the community, causing disease in otherwise healthy adults and children. These strains are resistant to the major class of antibiotics used to treat community-acquired staphylococcal infections. In a recent study, almost 60 percent of skin infections in adult emergency department patients in 11 U.S. cities were caused by MRSA, and invasive MRSA infections (both healthcare- and community-associated) are increasing in communities where these numbers are being tracked. Data suggest that between 8 and 20 percent of clinical MRSA isolates are community-associated. Resistance to the most effective antimicrobial drugs can require treatment with less effective and more expensive alternatives which may also be associated with a greater risk for side effects. CDC is working with other government agencies to implement a Public Health Action Plan to Combat Antimicrobial Resistance.

Another example is infections affecting populations. Infections are a major cause of morbidity among newborns in the U.S. and globally are one of the top causes of deaths in children under 5 years. The bacteria, Group B streptococcus (GBS) is a leading infectious cause of disease and death in the first week of life. Approximately 1 in 4 women carry the GBS bacteria and can pass it on to their newborns. Infections in newborns can be prevented by giving antibiotics during labor to women who tested positive for the bacteria late in pregnancy.

Surveillance is a key component of the public health system. Active Bacterial Core surveillance (ABCs) provides accurate, detailed estimates of serious infections that afflict persons of all ages in the United States. ABCs is active, laboratory and population-based surveillance for invasive infections, which include pneumonia, meningitis, and bloodstream infections. ABCs tracks the main causes of bacterial sepsis and meningitis in the U.S as well as sepsis in newborns. Current pathogens under surveillance: *Streptococcus pneumoniae*, group A streptococcus (GAS) and GBS, *Neisseria meningitidis*, *Haemophilus influenzae* and MRSA.

Keeping U.S. citizens and residents safe and healthy while traveling or living abroad is another priority of the CDC. CDC works to characterize the health risks associated with international travel and develops ways to reduce the associated morbidity and mortality. The principle activities are pre-event, prevention focused activities. CDC publishes the *Health Information for International Travelers* book (also known as The Yellow Book), which provides comprehensive prevention guidance and establishes the standard of care for the practice of travel medicine in the United States. The recommendations serve as a model for the rest of the world. The Yellow Book is also posted on the Travelers' Health website ([www.cdc.gov/travel](http://www.cdc.gov/travel)) where it is updated regularly to reflect current recommendations. The Travelers Health website also serves as a conduit for real-time delivery of prevention messages in response to specific events around the world and is tailored to selected target populations.

Furthermore, to prevent the importation of infectious diseases and other conditions of public health significance into the U.S., CDC works to promote and improve the health of immigrants, refugees and migrants and reduce health disparities among these populations. By actively improving the health of U.S.-bound refugees before their arrival, CDC increases the prospect for a successful resettlement in U.S. communities, reduces the need for substantial long-term health care services in the U.S., and protects the nation's health security by preventing the importation of disease.

### **RATIONALE FOR THE BUDGET**

The FY 2008 Budget of \$129,641,000 for Preparedness, Detection, and Control of Infectious Diseases reflects an increase of \$5,192,000 above the FY 2007 Continuing Resolution of \$124,449,000.

#### **Improving Special Pathogens Laboratory Capacity (+\$5.2 million)**

Infectious diseases continue to threaten our nation's health and that of every citizen in the world. Although great strides have been made toward preventing and controlling infectious diseases, it remains clear that a disease emerging in one country can rapidly lead to problems around the globe. The 2005 Marburg hemorrhagic fever outbreak in Angola reinforced the importance of global surveillance, prompt case reporting, laboratory capacity, and adequate containment measures to prevent a localized outbreak from

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spreading to other countries and becoming a pandemic. CDC was instrumental in the international response to assist Angola with the epidemiologic investigation, infection control, and lab diagnosis of this outbreak. This incident served as an example both of the threat of severe or fatal global diseases of unknown etiology with epidemic potential and of the public health preparedness and response infrastructure required to handle such high hazard pathogens.

CDC is well-known for its state-of-the-art maximum and high containment laboratories, in which scientists can work with highly pathogenic viruses and bacteria, and its integration of this laboratory capacity with subject matter and epidemiologic expertise. CDC's leadership in this area has made the agency a highly sought-after "one-stop shopping" resource for countries seeking assistance. Additionally, the control and prevention of person-to-person transmission of viral hemorrhagic fever outbreaks often center on assistance to the local medical establishment in strengthening infection control practices. The underlying epidemiology of many of these diseases is animal-borne, thus a strong ecological group has also been vital to understanding the reservoirs and vectors of disease transmission. Maintaining a basic science program and the ability to apply that knowledge to outbreak situations have always been strengths of CDC.

Increased funding for CDC's laboratory capacity in FY 2008 will build the agency's basic science program for high hazard pathogens, the cadre of scientists that populate it, and its capacity for outbreak response. Funds will strengthen and maintain the mixture of basic and applied science necessary to continue to respond with the best available science to an increasing number of new high pathogen agents. To do this, CDC must continue to recruit and maintain a cadre of scientists with experience and training to ensure its research, surveillance, detection, and response programs continue to remain on the forefront of infectious diseases diagnosis, characterization, and epidemiology.

## **PERFORMANCE ANALYSIS**

### **PART Results**

CDC maintains budget performance integration, cost evaluations and performance tracking. Through use of CDC agency-wide budget and performance software system, the center continues to track project budgeting, performance and outcomes. Cost efficiencies are also tracked through this system. Use of the system will continue and will evolve as additional needs arise.

Public information sharing continues to expand, including developing a website specifically devoted to cooperative agreements. Websites will be updated annually with new performance and award information. Specifically, a website was created by CDC's Infectious Diseases program to deliver performance data on grantees following its PART review. The website includes information on funding, activities, grantee contact information and website links, as well as Congressional summaries.

### **Current Activities**

- Continuing to build epidemiology and laboratory capacity in the U.S. by providing funds and technical assistance to 58 state, territorial, and local health departments. The funds are used to enhance national capacity to identify and monitor the occurrence of known infectious diseases of public health importance, detect new and emerging infectious disease threats, respond to disease outbreaks, and use public health data for priority setting.
- Continuing to train young scientists in public health laboratory practice as part of the Emerging Infectious Diseases Laboratory fellowship. Since its inception in 1995, approximately 314 scientists have participated in the program and have participated in over 158 disease outbreak investigations and co-authored more than 521 scientific publications.
- Monitoring changes in antimicrobial resistance of enteric bacteria over time to determine the burden of resistant disease and to develop interventions to reduce the burden of illness, through the National Antimicrobial Resistance Monitoring System for Enteric Bacteria, a collaborative effort among CDC, all 50 state health departments, and the Food and Drug Administration's (FDA) Center for Veterinary Medicine.
- Developing educational programs on the judicious use of antimicrobial agents specific for various animal species to encourage the appropriate use of antibiotics in livestock with the goal of reducing the amount of resistant enteric bacteria in food animals.
- Performing routine antifungal susceptibility testing to support surveillance studies, outbreak investigations, and external research collaborations.

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- Continuing to monitor and detect instances of naturally occurring health threats overseas and providing timely notices of these events. These notices are tailored towards how these threats affect U.S. citizens and residents traveling or residing overseas and are via the Traveler's Health website.
- Continuing to implement the Technical Instructions for Tuberculosis Screening and Treatment in priority countries as determined by immigration patterns and tuberculosis burden. Implementation of the new Technical Instructions will improve immigrant and refugee health, prevent importation of tuberculosis into the United States, and contribute to global tuberculosis control efforts.
- Working to improve the provisions for pre-departure malaria screening and treatment for U.S. bound refugees and immigrants from malaria endemic areas, as well as pre-departure intestinal parasite treatment.
- Convenes groups to develop neonatal sepsis guidelines and assess the impact of guidelines. CDC develops and maintains educational materials for patients and providers and maintains a website and outreach materials for minority groups. Globally, CDC is running a large randomized, controlled trial of an intervention of use of an inexpensive antiseptic, chlorhexidine, for the reduction of neonatal infections. In the past, CDC has developed guidelines for prevention of neonatal sepsis caused by GBS in the U.S. and is now a recognized leader in prevention in this field.

Prevent MRSA infections through adoption of evidence based prevention strategies

- Provide technical support and resources to MRSA prevention partners (eg., Institute for Healthcare Improvement (IHI), Centers for Medicare and Medicaid Services (CMS), Veterans Administration, Pittsburgh Regional Health Initiative).
- Monitoring invasive MRSA infection burden through ABC Surveillance system.
- Assess impact of interventions to prevent MRSA in National Healthcare Safety Network (NHSN) and related prevention process measures (e.g., adoption of Healthcare Infection Control Practices Advisory Committee (HICPAC MRDO) guideline recommendations).

Prevent healthcare-associated infections through adoption of evidence-based prevention strategies

- Reducing postoperative infections in partnership with the CMS sponsored Surgical Care Improvement Project.
- Monitoring the impact on healthcare associated infections of prevention measures (i.e., adoption of HICPAC guideline recommendations) in the NHSN.
- Determine the burden of key healthcare associated infections to monitor success toward preventing infections.
- Detection, investigation and control of emerging patient safety threats
- Detected and evaluated the emergence of new virulent strain of Clostridium difficile affecting U.S. hospital patients and led efforts to improve tracking and prevention of this emerging infection.
- Collaborate with FDA and other private and public partners to implement control measures to stop these threats.

Improve the healthcare delivery system's all-hazards preparedness and readiness to respond to natural and man-made threats.

- Lead the healthcare components (healthcare delivery, clinical care, infection control and healthcare surveillance) of pandemic flu preparedness and planning.
- Member of the CDC working group developing the American Medical Association (AMA/CDC) Congress and leading the exercise component of this Congress.
- Lead the development of tools, templates, exercises, and evaluations designed to assess and improve the healthcare delivery system's preparedness and readiness to respond to natural and man-made threats.
- Represent CDC on federal and external partner working groups addressing healthcare preparedness issues related to natural and man-made threats.

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Housing World Health Organization Collaborating Centers (WHOCC) associated with zoonotic, vector-borne, and enteric diseases, including those addressing parasitic, rickettsial, and neglected tropical diseases, poxviruses, and foodborne illnesses.

- Analyzing surveillance information and providing critical epidemiologic support for naturally occurring cases and/or outbreaks of plague, tularemia, and relapsing fever.
- Providing critical assistance to state public health laboratories, clinicians, and private laboratories on the accurate and timely identification of parasites and supporting outbreak investigations. This service is essential because the laboratory diagnosis of parasitic infections in the United States is hampered by the unfamiliarity of many laboratorians from the public and private sector with parasitic agents.
- Leading the public health response to newly approved blood donation screening test in the United States for serological evidence of infection with *Trypanosoma cruzi*, the parasite that causes Chagas disease by:
  - Issuing clinical management guidelines for those who test positive;
  - Providing anti-parasitic drugs to patients who test positive (because these drugs are only available through an Investigational New Drug protocol through CDC);
  - Providing laboratory testing to deferred blood donors and other patients to guide clinical management; and,
  - Providing health communication and health educational materials to the public, clinicians, state health departments, and industry since there is little expertise in the United States related to Chagas disease.
- Providing seven essential anti-parasitic drugs that would otherwise be unavailable to U.S. patients because they are not approved in the United States.
- Participating in an ongoing collaboration with the Environmental Protection Agency (EPA) in accordance with the Beaches Environmental Assessment and Coastal Health (BEACH) Act of 2000 which led to publication of data on water-borne illness acquired at fresh water beaches with preliminary data supporting the use of new, faster methods for screening recreational water quality at the beach.
- Developing and advancing methodology and technology to conduct molecular epidemiology, particularly to distinguish between various genotypes and subtypes of *Cryptosporidium* and *Giardia*, two waterborne infections that are commonly present in drinking and recreational water sources. Both are common in humans, domestic animals and wildlife, the latter two serving as zoonotic reservoirs for human infection and often source for contamination of source water.
- Evaluating new serologic tools and epidemiologic approaches to conduct surveillance for onchocerciasis, lymphatic filariasis, and schistosomiasis.
- Conducting a large randomized, controlled trial of an intervention of use of an inexpensive antiseptic, chlorhexidine, for the reduction of neonatal infections.
- Providing national leadership in formulating, evaluating and updating perinatal GBS disease prevention guidelines.
- Reaching African American and Hispanic women to help reduce racial disparities in newborn GBS disease through health communication materials and campaigns aimed at informing pregnant women, health care providers and clinical laboratorians about GBS disease prevention.
- Researching feasible interventions for the prevention of serious bacterial neonatal infections in developing countries.
- Consulting countries formulating GBS prevention guidelines.
- Providing technical support for pneumonia, meningitis and rotavirus surveillance sites and networks run through vaccine-specific initiatives working together to accelerate the development of vaccine programs globally.

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**Significant Accomplishments**

- 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, as well as systematic investigations to determine the causes of specific syndromes and serious illness in the U.S., including chronic liver disease, encephalitis, and respiratory diseases.
- Established domestic and global sentinel surveillance networks linking health care providers to improve the ability to detect and monitor emerging diseases. These networks include: (1) sentinels along the U.S.-Mexico border; (2) sentinel physicians for influenza; (3) travel medicine clinics in the U.S. and other countries; (4) academic hospital emergency departments; and, (5) infectious disease specialists throughout the U.S. These networks are uniquely capable of identifying and responding to newly emerging infections that require immediate attention.
- In collaboration with FDA's Center for Veterinary Medicine, launched surveillance of retail meat to determine the prevalence and antimicrobial resistance among the enteric bacteria found on retail meat purchased at grocery stores.
- Implemented the Organ Transplant Infection Project (OTIP), a collaborative project between CDC and six organ transplant centers to determine the clinical, immunologic, microbiologic, and environmental markers predicting occurrence of invasive fungal infections. Interim analysis of antifungal use patterns and susceptibility will lead to reduced morbidity and mortality among organ transplant recipients.
- Investigated and controlled a multi-state and international outbreak of Fusarium Keratitis infections associated with extrinsic contamination of a particular contact lens solution. After investigators found that patients were more likely to use the contact lens solution ReNu with MoistureLoc, the product was recalled and pulled from the market; no additional cases have occurred.
- Used CDC-developed molecular techniques for rapid genotyping of *Bacillus anthracis* isolates, a 2006 anthrax case in the U.S. was linked to an environmental isolate, showing that the case was not caused intentionally. This information allows CDC to more quickly determine the likelihood of a bioterrorism event.
- Worked with the American Water Works Association to develop and present a series of regional workshops for managers of large drinking water utilities and their corresponding local and state health department officials. These workshops promoted and strengthened interagency communication, collaboration, and coordination between the local health department officials and the managers of their corresponding community drinking water systems to better enable them to respond to a terrorist incident involving a community's drinking water.
- Developed a method for rapidly concentrating large volumes of water for detection of biological agents.
- Demonstrated through the National Health and Nutrition Examination Survey (NHANES) 1999-2004 survey a 36 percent reduction in *T. gondii* infection prevalence among U.S.-born persons. Attributed this reduction to likely be due to preventive efforts reducing *T. gondii* in meat and reducing exposure from cat feces/soil.
- Coordinated investigations of cyclosporiasis (a parasite that causes the infection, Cyclospora, which affects the small intestines (bowel)) in residents of 17 U.S. states and Canada in FY 2006, including at least three states and one province with event-associated clusters of cases; data from these investigations of multi-state/country outbreaks influenced federal regulatory policies, including new FDA import alerts in FY 2006 for two imported produce vehicles.
- Documented the impact of mass drug administration with diethylcarbamazine and albendazole on lymphatic filariasis and intestinal helminth infections in Leogane, Haiti. Findings from these studies have influenced global policies for the lymphatic filariasis elimination program.
- Published the 2007-2008 edition of the Yellow Book, Health Information for International Travel, through an innovative public-private partnership. The Yellow Book includes comprehensive prevention guidance and undergoes a major update every two years. It is also available on the Traveler's Health website where it is updated to reflect changing recommendations.

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- Facilitated the revision of the Technical Instructions for Tuberculosis Screening and Treatment, which had not been revised since 1991. The revised Technical Instructions move from a limited system to a proactive public health approach to tuberculosis screening and risk stratification that include improved diagnostic testing with cultures and drug susceptibility testing, directly observed treatment, and expanded TB screening to all ages.

**OUTPUT TABLE**

OUTPUT TABLE	FY 2006 ACTUAL	FY 2007 CR	FY 2008 BUDGET	FY 2008 +/- FY 2007
Number of domestic/global surveillance networks for emerging infectious diseases.	5	5	5	0
Number of EIP network sites	11	11	11	0
Number of state/local health departments, health care systems funded for surveillance, prevention, control of antimicrobial resistance	49	48	48	0
Number of grants for infectious disease research to academic institutions and states	40	40	40	0
Number of sites in the National Health Care Safety Network to report health care based reporting of adverse health events and errors	385	500	500	0

**FUNCTIONAL TABLE**

Preparedness, Detection, and Control of Infectious Diseases Budget by Functional Activity (Dollars in Thousands)	FY 2006 Actual	FY 2007 CR	FY 2008 Budget	FY 2008 +/- FY 2007
Preparedness, Detection, and Control of Infectious Diseases	\$20,252	\$20,263	\$20,263	\$0
All Other Emerging Infectious Diseases	\$104,116	\$104,186	\$109,378	\$5,192
<b>Total</b>	<b>\$124,368</b>	<b>\$124,449</b>	<b>\$129,641</b>	<b>\$5,192</b>

## HEALTH PROMOTION

HEALTH PROMOTION (DOLLARS IN THOUSANDS)	FY 2006 ACTUAL	FY 2007 CR	FY 2008 BUDGET	FY 2008 +/- FY 2007
BA	\$958,025	\$958,687	\$958,732	\$45

### **INTRODUCTION**

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

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

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

The coordination of these activities in the health promotion budget activity will assure the efficient and seamless interaction among its component programs and other CDC programs on cross-cutting health issues. For example, CDC's support of the Surgeon General's Family History Initiative draws on the expertise of chronic disease, genomics, and birth defects and promotes the health of the public through each of these areas. All activities within the Health Promotion budget activity will work together to foster cross-cutting health promotion programs.

## CHRONIC DISEASE PREVENTION, HEALTH PROMOTION, AND GENOMICS

### AUTHORIZING LEGISLATION

PHSA §§ 301, 307, 310, 311, 317, 317D, 317C, 317H, 317K, 317K(a), 317K(b), 317L, 317M, 327, 340D, 352, 391, 399B-399D, 399F, 399H-399L, 399W-399Z, 419C, 1102, 1501-1510, 1702(a)(2), 1702(a)(3), 1702(4)(A) and 1702(4)(C), 1703(a)(1), 1703(a)(2), 1703(a)(3), 1703(a)(4), 1703(c), 1704(1), 1704(2), 1704(3), 1706 Comprehensive Smoking Education Act of 1984, Comprehensive Smokeless Tobacco Health Education Act of 1986, Fertility Clinic Success Rate and Certification Act of 1992, Asthmatic Schoolchildren's Treatment and Health Management Act of 2004, Benign Brain Tumor Cancer Registries Amendment Act, Breast and Cervical Cancer Mortality Prevention Act, Prematurity Research Expansion and Education for Mothers who Deliver Infants Early Act (S. 707)

CHRONIC DISEASE PREVENTION, HEALTH PROMOTION, AND GENOMICS (DOLLARS IN THOUSANDS)	FY 2006 ACTUAL	FY 2007 CR	FY 2008 BUDGET	FY 2008 +/- FY 2007
BA	\$833,574	\$834,150	\$834,195	\$45

### STATEMENT OF THE BUDGET

The FY 2008 Budget of \$834,195,000 for Chronic Disease Prevention, Health Promotion, and Genomics reflects an increase of \$45,000 above the FY 2007 Continuing Resolution of \$834,150,000.

### PROGRAM DESCRIPTION

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

Cardiovascular disease (CVD) (including heart disease and stroke) alone is the leading cause of death in the U.S., affecting over 80 million Americans and costing the nation more than \$431 billion in direct and indirect health care costs per year. Much of the national burden could be prevented, but effective preventive measures are currently underused.

Cancer is the second leading cause of death in the U.S. In 2006, the direct and indirect costs of cancer in the U.S. totaled \$206 billion. Screening tests for breast, cervical, and colorectal cancer reduce the number of deaths from these diseases. Over 20 million Americans have diabetes, and the number of new cases is increasing steadily. Diabetes costs the nation nearly \$132 billion a year and can cause heart disease, stroke, blindness, kidney failure, pregnancy complications, and amputation of the leg, foot, and toe.

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

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

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-two percent of the adult population in the U.S. is obese and 17 percent of our children and adolescents are overweight. Obesity in the U.S. is truly epidemic.

Medical care for people with chronic diseases accounts for more than 83 percent of the \$1.4 trillion spent as a nation on medical care. Furthermore, if disease patterns stay the same, by the year 2030 the health care system will have

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to spend an additional \$300 to \$400 billion per year, excluding inflation, to treat the chronic diseases of an aging population. This expense means increased costs of \$1,500 per year per person in the U.S. just to help support the care of our older citizens.

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

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

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

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

Underpinning all of these efforts is surveillance (health tracking). Surveillance provides the information necessary to define the disease burden, identify populations at highest risk, and guide and evaluate disease prevention efforts at national, state, and local levels. CDC's Behavioral Risk Factor Surveillance System (BRFSS) is the nation's premier system for measuring critical health problems and a wide range of health-related behaviors in the U.S. adult population at the state and local level. Active in all 50 states, the District of Columbia, Puerto Rico, Guam, and the U.S. Virgin Islands, BRFSS is the primary source of information on major health risk behaviors of American adults. BRFSS provides timely and ongoing data collection that is flexible in order to meet individual state needs. CDC provides funding, consults with state staff, and assists states with editing and processing data. BRFSS data are the source for important public health messages, such as providing rapid data during the 2004-2005 influenza vaccine shortage and the obesity epidemic trend maps.

CDC's National Program of Cancer Registries (NPCR) collects data on the occurrence of cancer, including the type, extent, location of the cancer; and the type of treatment. In FY 2007, CDC will publish U.S. Cancer Statistics 2003: Incidence and Mortality, which includes data on 96 percent of the U.S. population.

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

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

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the value of genomic tests for population health for translation from research to practice. Genomics is a new science arising from the discoveries of the Human Genome Project. Although the terms genetics and genomics are sometimes used interchangeably, genetics is the study of inheritance or the way traits are passed down from one generation to another, whereas genomics is a newer term that describes the study of all the genes in a person, as well as interactions of those genes with each other and with that person's environment. Genetics usually refers to the study of single genes, while genomics refers to the study of all the genes in a person or organism. Genomics plays a part in nine of the ten leading causes of death in the United States such as heart disease, cancer, stroke, chronic lower respiratory diseases, diabetes, and Alzheimer's disease among others. All human beings are 99.9 percent identical in genetic makeup, but differences in the remaining 0.1 percent may hold important clues about the causes of disease. The study of genomics can help us learn why some people get sick from certain infections, environmental factors, and behaviors, while others do not. Better understanding of the interactions between genes and the environment will help us find better ways to improve health and prevent diseases.

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

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

### **RATIONALE FOR THE BUDGET**

The FY 2008 Budget of \$834,195,000 for Chronic Disease Prevention, Health Promotion, and Genomics reflects an increase of \$45,000 above the FY 2007 Continuing Resolution of \$834,150,000.

#### Adolescent Health Promotion Initiative (+\$17.3 million)

CDC is requesting \$17.3 million to support Secretary Leavitt's Adolescent Health Promotion Initiative, which aims to create a national culture of wellness that helps individuals take responsibility for personal health through actions such as regular physical activity, healthy eating, and injury prevention. Schools can play a critically important role in fostering a culture of wellness by teaching children and adolescents essential knowledge and skills for healthy eating, physical activity, and safety, and providing plenty of opportunities to practice those skills. This program will eliminate redundancy and duplication of tools and enable thousands of local schools to take full advantage of HHS's science-based resources to establish a culture of wellness that begins to halt the epidemic of childhood obesity plaguing our nation.

The proliferation of many different curriculum tools, public and private, has created confusion for some schools seeking evidence-based content on which to base health programs. The relative benefit of federally endorsed standards is diminished if there are multiple, overlapping or contradictory tools. This Adolescent Health Promotion Initiative will improve technical assistance to schools by providing a single school health assessment tool, the School Health Index.

The initial step in establishing a culture of wellness in schools is implementation of the School Health Index. Local schools use the Index to assess their health policies and programs and compare them to rigorous standards. Schools use the self-assessment findings to develop Action Plans, which identify the specific, research-tested strategies they will implement in areas such as physical education, health education, school lunch and school breakfast programs, beverages and snack foods sold at school, recess, intramural sports programs, and after school programs.

After completing the physical activity and nutrition modules of the School Health Index self-assessment process, schools will be able to apply to their State Education Agency for a School Culture of Wellness Grant. Awards ranging from \$3,000 - \$5,000 will be used to help schools implement HHS-developed tools relevant to the school wellness improvements featured in their Action Plans. Approximately 3,600 Culture of Wellness Schools will be funded around the country, directly reaching more than three million young people and their families. To help these schools

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effectively implement proven interventions, they will receive support such as product packaging, distribution, training, and Web and phone technical assistance. This technical assistance will subsequently be made available to help all schools in the nation become Culture of Wellness Schools. Trainings to help non-funded schools implement a culture of wellness through the use of the School Health Index and other HHS tools will be provided in 18 key metropolitan areas and via the Web.

**Steps to a Healthier U.S. (-\$17.2 million)**

Steps to a Healthier U.S. was funded for the first time in FY 2003 as a mechanism to assist 40 communities, cities, and tribal entities in implementing community action plans that build on existing local, state, and federal efforts related to obesity, diabetes, asthma and their risk factors. In addition, the plans include a special focus on populations with a disproportionate burden of disease and disparities in preventive services. Through the Steps program, organized community, environmental, educational, media, and policy interventions are being implemented in school, community, healthcare and workplace settings. The Steps program establishes an alliance of partnerships and coalitions committed to participating actively in planning, implementation, and evaluation activities. These partnerships track specific indicators of progress in conjunction with quantifiable program objectives. CDC is currently assessing experiences, successes, and lessons learned from the first Steps communities in order to inform future directions, especially in the area of how to achieve broader impact. With a decrease of \$17.2 million in FY 2008, the Steps programs that end their five year cycle will not be continued. Funding will be continued for the 13 programs that have not yet completed their five year cycle.

**PERFORMANCE ANALYSIS**

**PART Results**

In May 2006, the Chronic Disease Prevention Program as a whole underwent PART Review. Previously reviewed programs within Chronic Disease Prevention – the Breast and Cervical Cancer Program and Diabetes Program – were included as components of this overarching evaluation.

In preparing for the PART review, the Chronic Disease Prevention Program re-examined its strategic plan and long term and annual goals. Based on the budget, higher-level objectives, and public health needs, the program revised and re-prioritized Center goals and developed new, more outcome-oriented measures to base evaluation of performance. A detailed examination of processes and procedures was conducted to bring about improved public health outcomes as well as efficiency in the use of funds.

The program was rated as Moderately Effective and lauded for a clear and unique mission; effective surveillance systems; challenging but realistic quantifiable targets for long term and annual performance measures; commitments from partners; and for all aspects of program management.

Receiving a “moderately effective” instead of “effective” rating was mostly attributable to the newness of the goals and measures. Additionally, due to the size and complexity of the program, independent evaluations of the program as a whole had not been done; however, most of the divisions and smaller units within the Chronic Disease Prevention Program have had independent evaluations. The program has developed a plan to conduct a program-wide independent evaluation, in addition to stepping up independent evaluations of the divisions and sub-programs within the Center. Furthermore, the leadership and staff of the organization now have an updated strategic plan with a cohesive set of goals and outcome-oriented performance measures to focus program efforts. The program has a history of demonstrated achievement and progress toward the targets and measures and anticipates continued success in the years to come.

In addition, the Chronic Disease Prevention activity, along with other CDC programs, is participating in budget and performance integration efforts in accordance with CDC’s agency-wide program planning, tracking and performance measurement system.

**Current Activities**

- Improving CVD disease health and reducing ethnic and racial disparities by funding 33 state-based Heart Disease and Stroke Prevention programs. Eighteen states and the District of Columbia receive grants for planning and capacity-building, which prepares them for program implementation. Fourteen states receive grants for basic program implementation that:
  - Prevent and control high blood pressure and high blood cholesterol, major risk factors for heart disease and stroke;
  - Improve quality of care to prevent and manage high blood pressure, stroke, and heart disease; and

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- 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;
- Eliminates disparities

CDC also continues to support specific state and local-based research projects.

- Developing and implementing evidence-based nutrition and physical activity interventions through the National Nutrition and Physical Activity Program to Prevent Obesity and Other Chronic Diseases:
  - Funds seven states at the basic implementation level to conduct nutrition and physical activity interventions through population-based strategies, such as policy-level change, environmental change, and social marketing. Funds 21 states at the capacity-building level to form state-wide coalitions, develop state plans, and pilot test interventions in priority populations.
  - Conducts prevention research and health monitoring. CDC drafted recommendations for preventing and controlling obesity in the *Guide to Community Preventive Services*. CDC also published a research-to-practice series entitled "How to Use Fruits and Vegetables to Help Manage Your Weight", which examines the evidence from available studies to determine whether eating fruits and vegetables can help with weight management.
  - Reducing chronic disease risk factors such as poor eating habits, physical inactivity, and tobacco use through School Health programs funded in 23 states. CDC provides tools to states that strengthen and improve local school health programs. Through monitoring of youth risk behaviors and school health programs, science-based guidance, and support of program implementation and evaluation, CDC contributes to improvements in the quality of school health programs and policies.
- Providing young people with skills and information to avoid behaviors that put them at risk for HIV infection through school health programs in 48 states, seven territories, and 18 large city education agencies. CDC supports state and local education agencies in their efforts to help schools build the capacity required to provide effective HIV prevention education programs. Adolescents and young adults are a primary focus, particularly youth at greatest risk including minority races and ethnicities.
- Promoting access to quality diabetes care and services for people with diabetes by supporting 59 diabetes prevention and control programs in states, the District of Columbia, and U.S. territories through the National Diabetes Prevention and Control Program (DPCP). Twenty two states and the District of Columbia are funded at a capacity-building level. Twenty-eight states are funded at a basic implementation level. Basic implementation programs develop and promote diabetes care standards for adoption in health care delivery settings; help state Medicaid programs develop and monitor quality outcome measures for diabetes care; launch public and physician education campaigns to promote improved understanding and regular use of tests to determine average blood sugar levels; and involve communities in diabetes control activities, such as walking programs.
- Funding 33 PRCs, a national network of academic centers, public health agencies, and community partners are located in 26 states and collectively conduct about 500 research projects. Working with underserved communities, each PRC is developing strategies for preventing and controlling chronic diseases and assisting communities in adopting and sustaining these changes. Research conducted addresses issues, such as nutrition and physical activity to prevent obesity, diabetes, and heart disease; healthy aging; healthy youth development, including prevention of violence and substance abuse, strengthening family and community relationships to support healthy lifestyles; and controlling cancer risk and other health disparities.
- Establishing broad-based Comprehensive Cancer Control (CCC) coalitions, assessing the burden of cancer, determining priorities for cancer prevention and control, and developing and implementing comprehensive cancer control plans, in collaboration with public health agencies through CDC's CCC program. CDC supports 63 CCC programs across the U.S., including 50 states, the District of Columbia, six tribes and tribal organizations and six U.S. Associated Pacific Islands/territories.
- Conducting breast and cervical cancer screening and early detection programs through National Breast and Cervical Cancer Early Detection Program (NBCCEDP) in all 50 states, four territories, the District of Columbia, and 13 American Indian/Alaska Native tribal organizations. The Breast and Cervical Cancer Prevention and Treatment Act of 2000 gave states the option to choose to extend Medicaid coverage to women screened in the NBCCEDP and diagnosed with cancer for the duration of their treatment. All 50 states and the District of Columbia have received approval. In addition, CDC works with grantees to ensure treatment for women who are not eligible to enroll in the Medicaid option. Several activities have been identified as priorities for CDC, including implementing evidence-based recruitment interventions and

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increasing the efficiency of the NBCCEDP. CDC has completed the program's strategic and evaluation plan and is in the process of developing and tracking health outcome measures.

- Evaluating cancer prevention and control program activities through essential state cancer registry data. CDC supports 45 states, three territories, and the District of Columbia for cancer registries through the National Program of Cancer Registries. For example, cancer registry information can be used to target specific populations for breast, colorectal, and cervical cancer screening.
- Educating the public about the benefits of screening, the availability of current screening procedures, and screening guidelines in order to promote national colorectal cancer screening.. To this end, CDC educates Americans aged 50 years or older about the importance of colorectal cancer screening with its national colorectal cancer action campaign, Screen for Life. Additionally, CDC works with national partners and organizations to educate medical providers and the public about the importance of colorectal cancer screening. Further, CDC supports epidemiological, behavioral science, and surveillance research efforts to gather and analyze data, and funds prevention and intervention research projects and investigations related to colorectal cancer.
- Increasing colorectal cancer screening among low income adults, aged 50 years and older who have little or no health insurance coverage for regular screenings through five colorectal cancer screening demonstration programs. These programs will provide screening for colorectal cancer, as well as provide medical follow-up services, conduct public education and outreach, and evaluate the effectiveness of the demonstration program.
- Implementing activities in state action plans to reduce pain, increase and maintain function, and improve the quality of life of people with arthritis, promoting key public health messages, and providing evidence-based interventions to high need populations with partner organizations in states funded to enhance public health activities for arthritis. CDC developed and rolled-out a health communications campaign, Physical Activity. The Arthritis Pain Reliever, which targets low income African-American and Caucasian people age 45-64, and is used in most of the funded states and many local chapters of the Arthritis Foundation.
- Promoting oral health nationwide, monitoring oral health status and behaviors, providing guidance on safe office infection control practice, fostering applied research to document the effectiveness of community- based programs, and providing tools that can assist programs in CDC-supported state and community oral disease prevention programs. CDC funds 12 states and one territory for capacity building activities aimed at strengthening their oral health programs and reducing inequalities in the oral health of their residents. Additional funds are provided to some of these states to build capacity for two proven disease prevention strategies, community water fluoridation and school-based or linked dental sealant programs.
- Reducing tobacco-related death and disease by preventing youth from initiating tobacco use, helping smokers' quit, reducing exposure to involuntary tobacco smoke, and eliminating tobacco-related disparities. CDC uses a cross-cutting approach that includes conducting surveillance and prevention research, collaborating with public health stakeholders, and supporting comprehensive tobacco prevention and control programs in all 50 states and the District of Columbia through funding and technical assistance. CDC also supports 12 organizations with access to diverse populations, six tribal organizations and six national networks, and funds a campaign targeting rural youth. These comprehensive programs use evidence-based interventions that have been proven to be successful and produce dramatic results when fully implemented. CDC collaborates with public health stakeholders to support a National Network of Tobacco-Use Cessation Quitlines to provide smokers with the help they need to quit.
- Initiating and implementing chronic disease prevention efforts in communities across the country consisting of cities, counties (through states) and tribal entities through Steps to a HealthierUS. The Steps program acts as a catalyst to make urgently-needed changes in local communities related to physical inactivity, poor nutrition, and smoking to combat the rising rates of obesity, diabetes, and asthma among adults and youth. Successes and models for local action from Steps can be replicated by other communities. Special focus is directed toward populations with disproportionate burden of disease and lack of preventive services. Through the Steps program, local communities are empowered to implement evidence-based interventions in their community, schools, workplaces, and health care settings that will make a positive difference in the environment, access to care, and policies related to the focus areas and risk factors.
- Designing, implementing, and evaluating culturally appropriate and community-driven strategies to reduce and eliminate health disparities in racial and ethnic minority communities through CDC's Racial and Ethnic Approaches to Community Health (REACH) program. Target populations are African-Americans, American Indians, Hispanic-Americans, Asian-Americans, Pacific Islanders, and Alaska Natives. A new grant cycle beginning in FY 2007 will expand the application, synthesis, and dissemination of best practices to eliminate racial and ethnic health disparities, building on successes, strong demonstrated outcomes, and the body of

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knowledge being built through REACH. An open competition in FY 2007 will allow new communities to apply to be REACH Centers of Excellence or Action Communities. A new dissemination mechanism will spread effective strategies from REACH by funding at least 24 additional "legacy communities," which will be awarded as sub-recipients of the REACH Centers of Excellence, and receive mentoring and support from these Centers. An open competition in FY 2007 will allow new communities to apply to be REACH Centers of Excellence or Action Communities. A new dissemination mechanism will spread effective strategies from REACH by funding at least 24 additional "legacy communities," which will be awarded as sub-recipients of the REACH Centers of Excellence, and receive mentoring and support from these Centers. CDC will continue to provide qualitative and quantitative assessments of the REACH program.

- Funding 37 states, New York City and the South Dakota Yankton Sioux Tribe to conduct the Pregnancy Risk Assessment Monitoring System (PRAMS), representing 75 percent of U.S. live births. PRAMS collects information on pregnancy-related morbidity, access to and use of prenatal care, physical violence during pregnancy, obstetric history and nutrition, alcohol and tobacco use during pregnancy, infant health care, infant sleeping position, and economic status of the mother.
- Revised the 1996 Guidelines for Death Scene Investigation of Sudden Unexplained Infant Deaths (SIDS) and the SIDS Investigation Report Form, to provide consistent information across the country regarding SIDS deaths. Consistent information will enable preventive measures for SIDS to be developed and implemented. In FY 2007, CDC will conduct five regional Train-the-Trainer Academies for investigators and death certifiers to consistently collect data at the death scene and accurately report their findings on the death certificate.
- Collaborating with federal agencies, academia, and state health departments to evaluate whether family history information can be used to assess risk for common diseases and influence early detection and prevention strategies. The Family History Public Health Initiative developed an evaluation framework for assessing the analytic validity (how accurately disease among relatives is reported), clinical validity (ability of family history to predict future disease), clinical utility (risks and benefits of the approach), and the ethical, legal and social implications of collecting and using family history information. Ongoing work includes pilot studies to further refine the family history tool, development of algorithms to assess risk, development of a resource manual for primary care providers, and design and funding of studies to evaluate the validity and utility of the approach.
- Pilot-testing CDC's Family Healthware, a web-based prototype family history tool created for the Family History Public Health Initiative, in a variety of public health and preventive medicine settings. CDC is currently funding three research centers, the University of Michigan School of Medicine, Evanston Northwestern Healthcare Research Institute, and Case Western Reserve University School of Medicine, to conduct a collaborative study set in primary care clinics. The study will determine whether family history risk assessment, classification, and personalized prevention messages influence health behaviors and the use of preventive medical services.
- Supporting Evaluation of Genomic Applications in Practice and Prevention (EGAPP), a model project launched in 2004 to implement and evaluate a coordinated, systematic, evidence-based process for assessing genetic tests and other applications of genomic technology that are in transition from research to clinical and public health practice. Roles of the 13-member, independent, non-federal EGAPP Working Group, established in 2005, include prioritizing and selecting potential topics for review; specifying methods for evidence reviews and outcomes to be considered; and developing recommendations based on the evidence. Additional project activities include engaging stakeholders to help develop and disseminate targeted messages based on the evidence and recommendations, planning for a 2007 survey of stakeholders to assess EGAPP's value and impact, and exploring ways to develop a sustainable, EGAPP- like process.
- Conducting analyses of human genomic data in acute public health investigations (APHIs) to enhance our ability to assess the effectiveness and side effects of therapeutics and vaccines; characterize environmental exposure more accurately; understand variation in disease outcomes; and refine public health interventions such as vaccination, chemoprophylaxis, exposure reduction, behavior modification, and education. A CDC-wide team is collaborating with NIH to measure population variation in selected genes using stored DNA samples collected during the third National Health and Nutrition Examination Survey (NHANES III). This collaboration will help develop genotype prevalence estimates based on a nationally representative sample of the U.S. population. Data collected from NHANES continues to add another dimension to the analysis of clinical, physical, and lifestyle information by creating a resource for analysis of genotype-phenotype correlations and gene-environment interactions.

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- Funding genomics programs in the state health departments of Michigan, Minnesota, Oregon, and Utah to integrate genomics knowledge, tools (e.g., family history assessments) and surveillance findings into activities and strategies of chronic disease prevention programs.
- Funding Centers for Genomics and Public Health at Schools of Public Health at the University of Michigan and the University of Washington which serve as regional hubs of expertise in genomics and public health with a focus on translating genomic information into useable public health knowledge, providing technical assistance to state and community public health agencies and integrating genomics into programs and practice. The Centers are also working collaboratively with the Office of Public Health Genomics on several key projects, such as the EGAPP Project and the Family History Initiative.
- Established the Human Genome Epidemiology Network (HuGeNet), a global collaboration of 400 individuals and 17 organizations committed to assessing the role of human genome variation in population health and the potential of genomics for improving health and preventing disease. HuGeNet is promoting publication of systematic reviews of population-based data on genotype prevalence, gene-disease associations, and gene-environment interactions. Recent partners include coordinating centers in the United Kingdom, Canada, and Greece. In 2006, HuGENet published the first edition of an online handbook for systematic reviews, which are peer reviewed and published in partnership with ten scientific journals.
- Funding the Jeffrey Modell Foundation (JMF) to support awareness campaigns related to primary immune deficiencies through dissemination of materials and provision of educational sessions. This campaign aims to prevent chronic problems or death arising from the inability to fight off common childhood infections often not diagnosed in time. Primary immune diseases affect 500,000 persons and often have the greatest impact in children.

**Significant Accomplishments**

- In six state trauma regions, the Kansas Heart Disease and Stroke Prevention Program implemented policies standardizing training for emergency medical dispatchers (EMDs). Training helps EMDs recognize signs and symptoms of heart attack and stroke and better manage services to the victim. Over 300 EMDs have been trained.
- Published CDC's Weight Management Research to Practice series which summarizes the science on weight management topics for health professionals and the general public. An overview of the science is compiled into a document appropriate for public health professionals. In addition, some installments in the series are accompanied by a brochure geared toward the public. These companion brochures are designed for practitioners to use with their clients and patients to explain concepts correctly and provide practical tips on implementing strategies to help manage weight.
- Increased the number of women served through WISEWOMAN to more than 12,000 in 2006. WISEWOMAN provides screening and lifestyle interventions that can reduce risks for heart disease and other chronic diseases and positively impacts the lives of underserved women and improving women's cardiovascular health profile. A total of 77,500 women have been served and more than 100,000 lifestyle interventions have been provided since program inception. For women who entered the program from 2000-2005, cholesterol levels dropped after one year from 211 milligrams per deciliter to 206, and their estimated risk of heart attack in the next five years decreased.
- The proportion of fully tobacco free secondary schools increased from 37 percent in 1994 to 46 percent in 2000 and a large and growing number of schools have recently improved the nutritional quality of food and beverage items sold in vending machines. School health policies and programs have contributed to recent decreases in health risk behaviors among high school students, including the decline in cigarette smoking rates from 36 percent in 1997 to 23 percent in 2005.
- Between 1991 and 2005, the percentage of high school students who: had ever had sexual intercourse decreased from 54 percent to 47 percent; used a condom at last sexual intercourse increased from 46 percent to 63 percent; had multiple sex partners decreased from 19 percent to 14 percent; and had been taught about HIV and AIDS in school increased from 83 percent to 88 percent.
- Provided over six million screening tests to over 2.7 million women through the NBCCEDP. The program has diagnosed 26,907 breast cancers, 88,847 precancerous cervical lesions, and over 1,725 cases of invasive cervical cancer.
- Collaboration between two CDC-supported state programs, the Illinois Breast and Cervical Cancer Program and the Illinois Cancer Registry, led to an increase in the percentage of women diagnosed at the earliest stages of breast cancer. In counties that participated in the program for at least five years, the percentage

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- of breast cancer cases diagnosed at the earliest stage increased 110 percent. Counties not participating in the program did not experience such an increase.
- The PRCs continued to develop adoptable, effective and promising interventions. The University of Washington PRC is finding through its Program to Encourage Active, Rewarding Lives for Seniors (PEARLS) that depressive symptoms among homebound, chronically ill, and frail low-income older adults can be reduced through counseling on three depression management techniques. After one year, 43 percent of seniors in the intervention group reported at least a 50 percent decline in depressive symptoms, compared to only 15 percent of seniors in the control group. Depression resolved completely for three times as many PEARLS participants than non-participants. The Columbia University PRC is partnering with community organizations in Harlem to evaluate the impact of an asthma intervention on children in the area. Preliminary results show significant reductions in school absenteeism, emergency department and unscheduled physician visits, and hospitalization for children with asthma.
  - More Americans have access to effective tobacco-use cessation services than ever before. Through the National Network of Tobacco Use Cessation Quitlines, 50 states and five jurisdictions have active quitlines. Last year, through CDC's collaborative efforts, the Centers for Medicare and Medicaid Services (CMS) added smoking cessation counseling as a benefit for Medicare recipients. CDC successfully collaborated with the Office of the Surgeon General to release *The Health Consequences of Involuntary Exposure to Tobacco Smoke, A Report of the Surgeon General*, the most comprehensive and most authoritative scientific report yet issued on the health risks of secondhand smoke.
  - The Steps to a HealthierUS Program has experienced the following programmatic successes including: reducing obesity and health care costs in workplaces; creating healthier school environments including smoking bans, provision of nutritious foods, and physical activity enhancements; implementing clean indoor air ordinances; and reducing A/C levels among diabetes patients.
  - REACH continued to build healthy communities and reduce minority health disparities. Between 2001 and 2004, data from the REACH risk factor survey show that in communities that are focusing on cardiovascular disease and/or diabetes: the proportion of Hispanics having cholesterol checks increased by 40 percent as compared to a small decline in the general U.S. population; the proportion of hypertensive American Indians on medication increased by ten percent compared to a six percent increase nationally; cigarette smoking among Asian American men decreased by more than 30 percent versus a six percent decline nationally, and the proportion of African Americans that have had their cholesterol checked increased compared to a small decline nationally.
  - Buenos Dias, Arthritis, a Spanish-language health communications campaign promoting physical activity among people with arthritis of Hispanic descent, was released in December 2006. State arthritis programs and local chapters of the Arthritis Foundation will use this campaign to reach Spanish-speaking Hispanic audiences.
  - CDC completed development of a web-based tool, Family Healthware™, that collects information about health behaviors, screening tests, and personal family histories for six diseases: coronary heart disease, stroke, diabetes, and colorectal, breast, and ovarian cancer. CDC funded three research centers to conduct a clinical trial of Family Healthware™. The study, consisting of approximately 6,000 patients who attend primary care practices, will measure whether family history risk assessment, stratification, and personal prevention messages influence health behaviors and use of medical services.
  - CDC collaborated with the Council of State and Territorial Epidemiologists (CSTE) to form a multidisciplinary APHI working group to outline key research priorities for incorporating genomics into APHIs at the state and federal levels. Next steps include assessing and developing public health genomics capacity, and addressing laboratory, analytical, informatics, DNA specimen banking, and ethical, legal, and social issues.
  - In collaboration with CDC, the Centers for Genomics and Public Health completed two web-based training programs for public health professionals. The first is an introductory presentation called Genomics for Public Health Practitioners that describes the application of genomics to public health; dispels myths; and identifies challenges in public health genomics. The second is a more in-depth series, Six Weeks to Genomics Awareness, which includes six presentations designed to help public health professionals understand how genomic advances are relevant to public health.
  - With CDC support, the Jeffrey Modell Foundation has: increased outreach measured by an increase in telephone hotline calls and nearly 700,000 website hits per month; reached 92.4 million American households with a 30 minute educational program on Primary Immunodeficiency (PI) aired nationally; provided 38,000 school nurses with an information kit; and secured \$10.5 million worth of donated media time for Public Service Announcements.

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**OUTPUT TABLE**

OUTPUT TABLE	FY 2006 ACTUAL	FY 2007 CR	FY 2008 BUDGET	
Heart Disease and Stroke				
States funded for capacity-building CVD prevention programs (includes D.C.)	19	19	19	0
States funded for basic implementation CVD prevention programs	14	14	14	0
Surveillance and research studies describing the CVD burden and developing effective intervention strategies	21	21	21	0
State health departments funded for ongoing state stroke registries to assess stroke treatment and improve the quality of care for acute stroke patients	4	4	4	0
Cancer Prevention and Control				
States funded for Comprehensive Cancer Control (includes 6 tribes and tribal organizations, the District of Columbia and 6 U.S. Associated Pacific Islands/territories)	55	62	62	0
Cancer Registry states/territories with capacity-building programs	3	3	3	0
Cancer Registry states/territories with basic implementation programs	46	46	46	0
Cancer Registry Programs submitting data to the NPCR Cancer Surveillance System	48	48	48	0
Education campaign to promote colorectal cancer screening	1	1	1	0
Number of breast and cervical cancer screening programs	68	68	68	0
Number of states, territories, AI/AN tribes provided consultation and scientific expertise to support screening programs	68	68	68	0
Number of cooperative agreements to national partners and professional societies to promote cancer prevention	17	17	17	0
Diabetes				
Number of state-based Diabetes Prevention & Control Programs: Capacity-building (including DC)	23	23	23	0

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HEALTH PROMOTION  
CHRONIC DISEASE PREVENTION, HEALTH PROMOTION, AND GENOMICS

OUTPUT TABLE	FY 2006 ACTUAL	FY 2007 CR	FY 2008 BUDGET	
Number of state-based Diabetes Control Programs: Basic Implementation	28	28	28	0
Number of territories/jurisdiction funded for capacity-building Diabetes Control Programs	8	8	8	0
Health education programs/ community interventions targeting minority populations	16	16	16	0
Number of childhood diabetes surveillance systems	6	6	6	0
Number of state-based pilot projects for the primary prevention of diabetes	5	5	5	0
<b>Health Promotion</b>				
Number of state tobacco prevention and control programs (includes DC)	51	51	51	0
Tobacco Cessation Quitlines – States/ Territories/ Tribes funded to implement quitlines	19	19	19	0
Tobacco Cessation Quitlines – States/ Territories/ Tribes funded to enhance existing quitlines	36	36	36	0
Number of cooperative agreements for tobacco prevention with key organizations with access to diverse population	12	9	9	0
Scientific, technical, and public inquiry response on tobacco use	50,000	50,000	50,000	0
Total state health departments and other organizations (e.g., local health departments) requesting advertising campaign materials through the Media Campaign Resource Center	250	250	250	0
New methods to measure constituents in tobacco or tobacco smoke	4	4	4	0
Countries in which Global Youth Tobacco Survey have been implemented	163	163	163	0
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	39	39	39	0
States with Maternal and Child Health (MCH) epidemiologist	16	16	16	0

**NARRATIVE BY ACTIVITY**  
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**CHRONIC DISEASE PREVENTION, HEALTH PROMOTION, AND GENOMICS**

OUTPUT TABLE	FY 2006 ACTUAL	FY 2007 CR	FY 2008 BUDGET	
Research projects in MCH	2	2	2	0
Number of population-based registries to define and monitor the incidence and prevalence of lupus	2	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
Steps to a <i>HealthierUS</i>				
Number of local health depts. to fund large city and urban communities	12	12	6	(6)
Number of state health depts. to fund state-coordinated small city and rural communities (each state funds an average of 4 communities)	7	7	5	(2)
Number of tribal organizations	3	3	1	(2)
National Organizations	1	1	1	0

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OUTPUT TABLE	FY 2006 ACTUAL	FY 2007 CR	FY 2008 BUDGET	
REACH 2010				
REACH Centers of Excellence	0	12	12	0
REACH Action Communities	0	20	20	0
REACH Legacy Communities	0	24	24	0
REACH community projects (grant cycle ended in 2006)	40	0	0	0
Adolescent Health				
Number of schools participating in the School Health Index, including development of action plans to improve physical activity and nutrition policies to prevent obesity.	2,500	3,000	10,000	7,000

**FUNCTIONAL TABLE**

CHRONIC DISEASE PREVENTION, HEALTH PROMOTION, AND GENOMICS (DOLLARS IN THOUSANDS)	FY 2006 ACTUAL	FY 2007 CR	FY 2008 BUDGET	FY 2008 +/- FY 2007
Heart Disease and Stroke	\$44,237	\$44,269	\$44,269	\$0
Diabetes	\$62,763	\$62,806	\$62,806	\$0
Cancer Prevention and Control	\$306,197	\$306,409	\$306,409	\$0
Arthritis and Other Chronic Diseases	\$21,995	\$22,010	\$22,010	\$0
Tobacco	\$104,169	\$104,241	\$104,241	\$0
Nutrition, Physical Activity, and Obesity	\$41,280	\$41,309	\$41,309	\$0
Health Promotion	\$27,273	\$27,290	\$27,290	\$0
School Health	\$55,854	\$55,893	\$55,893	\$0
Safe Motherhood/Infant Health	\$44,044	\$44,074	\$44,074	\$0
Oral Health	\$11,621	\$11,629	\$11,629	\$0
Prevention Centers	\$29,536	\$29,556	\$29,556	\$0
STEPS to a HealthierUS	\$43,611	\$43,641	\$26,386	(\$17,255)
Racial and Ethnic Approach to Community Health (REACH)	\$34,080	\$34,104	\$34,104	\$0
Genomics	\$6,914	\$6,919	\$6,919	\$0
Adolescent Health	\$0	\$0	\$17,300	\$17,300
Total	\$833,574	\$834,150	\$834,195	\$45

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## BIRTH DEFECTS, DEVELOPMENTAL DISABILITIES, DISABILITY AND HEALTH

### AUTHORIZING LEGISLATION

PHSA §§ 301,307,310,311,317 , 317C, 317J, 327, 352, 399G, 399H, 399I, 399J, 399M,1102, 1108: PHSA Title IV

BIRTH DEFECTS, DEVELOPMENTAL DISABILITIES, DISABILITY AND HEALTH (DOLLARS IN THOUSANDS)	FY 2006 ACTUAL	FY 2007 CR	FY 2008 BUDGET	FY 2008 +/- FY 2007
BA	\$124,451	\$124,537	\$124,537	\$0

### STATEMENT OF THE BUDGET

The FY 2008 Budget of \$124,537,000 for Birth Defects, Developmental Disabilities, Disability and Health reflects level funding with the FY 2007 Continuing Resolution.

### PROGRAM DESCRIPTION

The mission of CDC's Birth Defects, Developmental Disabilities, Disability and Health activity is to promote the health of babies, children and adults and enhance the potential for full, productive living. In support of its mission, the program has adopted two long-term goals: 1) Prevent or reduce birth defects and developmental disabilities; and 2) Improve the health & development of all people with disabilities and potentially disabling conditions.

Each year, an estimated 4 million families in the United States experience the joy of bringing a child into the world. Unfortunately, 1 in 33 of these children is born with a serious birth defect. Birth defects are the leading contributor to infant mortality in the U.S. and, in 2002, accounted for one out of every five infant deaths. With advances in medical treatment and technology, many infants born with even the most severe defects survive beyond infancy into childhood and adulthood. With more than 120,000 babies born each year with a serious birth defect, the social and economic burden on families and communities is immense. Lifetime costs for infants born with 1 or more of the 17 most clinically important birth defects are estimated to cost \$6 billion per year.

Developmental disabilities are a diverse group of conditions characterized by physical, cognitive, psychological, sensory, or speech impairments. While developmental disabilities can begin anytime during development through 18 years of age, many of these conditions have genetic causes or are thought to be influenced by factors that occur during pregnancy or shortly after birth. Approximately 17 percent of U.S. children less than 18 years of age have a developmental disability, and approximately 1.4 million children—or 2 percent of U.S. school-aged children—have a serious developmental disability that often requires lifelong supportive services. In addition to the substantial emotional impact on families, developmental disabilities are expensive to communities and society as a whole. For children born with mental retardation in 2000, the estimated lifetime costs in 2003 dollars exceed \$50 billion.

With fifty-four million Americans living with a functional limitation associated with a long-term physical, sensory, or cognitive condition, promoting the health and well-being of people of all ages with disabilities has emerged as a public health priority. The annual economic cost associated with disabling conditions is an estimated \$300 billion. Research shows that people with disabilities often have more problems accessing social and recreational activities, employment, and health care compared to people without disabilities. Lack of access can serve as a barrier to healthy living. People with disabilities report higher rates of depression, anxiety, obesity, and acute pain than do non-disabled persons. Recent data suggest that more people with disabilities smoke and have high blood pressure and high cholesterol than their non-disabled counterparts.

In support of the goal to prevent or reduce birth defects and developmental disabilities, CDC sponsors surveillance, research, intervention and prevention activities. Because the causes of 70 percent of birth defects and 75 percent of developmental disabilities are unknown, surveillance and research activities remain critical components of CDC's efforts to address these public health issues. Through these efforts, CDC aims to identify and address the causes of birth defects and developmental disabilities. When causes or risk factors are known, CDC supports the development and evaluation of prevention and intervention strategies.

To improve the health of all people living with a disability or potentially disabling condition, CDC sponsors data collection on the prevalence of disabilities and health status of people with disabilities, research on risk factors for poor health outcomes associated with disabilities and potentially disabling conditions, and health promotion programs designed for people with disabilities.

## **RATIONALE FOR THE BUDGET**

The FY 2008 Budget of \$124,537,000 for Birth Defects, Developmental Disabilities, Disability and Health reflects level funding with the FY 2007 Continuing Resolution.

## **PERFORMANCE ANALYSIS**

### PART Results

In May 2006, the Birth Defects and Developmental Disability program underwent PART Review. In preparing for the PART review, the program developed a strategic plan and long term and annual goals. Based on the budget, higher-level objectives, and public health needs, the program revised and re-prioritized Center goals and developed new, more outcome-oriented measures to base evaluation of performance. A detailed examination of processes and procedures was conducted to bring about improved public health outcomes as well as effectiveness and efficiency in the use of funds.

The program was rated as Moderately Effective. PART findings included success in addressing specific public health problems in the areas of birth defects, developmental disabilities and health for people living with these and other disabilities, including inherited blood disorders. Additionally, evaluators commended the program for challenging but realistic quantifiable targets and timeframes for the long-term outcome measures.

Receiving a "moderately effective" rather than "effective" rating was mostly attributable to the newness of the goals and measures. However, the program has a history of demonstrated achievement and progress toward the targets and measures and anticipates continued success in the years to come.

In addition, the Birth Defects and Developmental Disabilities activity, along with other CDC programs, is participating in budget and performance integration efforts in accordance with CDC's agency-wide program planning, tracking and performance measurement system.

### Current Activities

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

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- Diabetes during pregnancy and birth defects: CDC has conducted focus groups of pregnant women with diabetes to learn about their knowledge of diabetes during pregnancy, pregnancy outcomes, management of diabetes during pregnancy, and potential barriers to such management. CDC is currently analyzing these data and preparing a report on the findings.
- 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 conducting activities to determine how best to reach these women with the folic acid message, as well as exploring opportunities to work with manufacturers to voluntarily fortify corn flour – a staple of the Hispanic diet – with folic acid.
- 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; develop research programs to identify and test new FAS prevention and management methods; establish regional training centers to increase health care providers' promote knowledge about how to identify and prevent FAS; and develop prevention and education materials for parents, educators, students, professionals, and the public at-large. In addition, CDC provides support to all 50 states to monitor alcohol consumption levels, and supports targeted outreach to American Indian/Alaskan native populations.
- CDC works with the American College of Obstetricians and Gynecologists to develop user-friendly educational materials for providers regarding screening for alcohol use during pregnancy and brief interventions for women at risk for an alcohol-exposed pregnancy. Materials have been developed and are currently being disseminated.
- Awareness Campaign: CDC and its partners continue to conduct "Learn the Signs. Act Early", a campaign to promote early identification and intervention for children with autism and other developmental disabilities. The campaign activities have included the creation and distribution of healthcare professional as well as parent resource kits, public service announcements, maintenance of a call center and widespread new media coverage in national outlets.
- Autism and Developmental Disabilities Tracking and Research: CDC operates a model tracking and research program to determine the prevalence of autism and other common developmental disabilities (including mental retardation, cerebral palsy, vision impairment, and hearing loss) and conduct research on the causes of these conditions. In addition, CDC supports autism monitoring and research in other parts of the country. Including CDC's program, a total of 10 states are now tracking rates of autism and other developmental disabilities in children, with six of these programs also conducting public health research on autism.
- CDC has engaged the Institute of Medicine to *Disability in America*. In partnership with other federal agencies and the IOM, CDC expects to release its findings in 2007.
- CDC supported the development of a Caregiver survey module to better understand the rates of caregiving by state and the health effects of caregiving. This topic is particularly important as the burden of caregiving is expected to increase significantly with the aging of the population.
- CDC, along with HHS Office on Disability, worked to produce A Surgeon General's Call to Action to Improve the Health and Wellness of Persons with Disabilities and is taking an active role in chairing a workgroup to implement the recommendations in the document. The "Call to Action" is the seminal federal document that encourages health promotion activities for persons with disabilities. It identifies four overarching goals and reaches out to public, private, academic, administrative, policy-oriented, clinical, consumer and family audiences.
- CDC continues to work closely with grantees in Arkansas to understand the health of adolescents and young adults living with Spina Bifida. With increasing survival rates, it is important to understand the health and health promotion needs of this population. CDC's work in this area is a model for promoting optimal health and wellness for individuals with other disabilities.
- The Amputee Coalition of America, a CDC grantee, continues to take a national leadership role in providing support to military veterans with newly acquired limb loss, and has developed and implemented an award winning Peer Support System for veterans, including those injured in recent military campaigns.

## BIRTH DEFECTS, DEVELOPMENTAL DISABILITIES, DISABILITY AND HEALTH

- The American Association on Disability and Health, in partnership with The CDC and Special Olympics, Inc, sponsored a national meeting in July 2006 in Ames, Iowa for the CDC funded grantees and partner organizations to meet, give and receive technical assistance, and develop new collaborations and partnerships.
- CDC supports 30 states and territories in their efforts to develop surveillance and tracking systems to ensure all newborns are screened for hearing loss and that, when necessary, infants receive appropriate follow up testing and services. Recent CDC data have shown that approximately 90 percent of the infants born in the United States were screened for hearing loss. CDC will work to increase the percentage of infants referred for a diagnostic evaluation who receive an audiological diagnosis and the percentage of infants with hearing loss who are enrolled in early intervention.
- CDC funds research projects investigating a wide range of topics such as risks factors for late-onset hearing loss in children, prevalence and effects of early intervention children with unilateral hearing loss, and the use of birth certificate information to improve lost to follow-up rates. The results of these studies will provide essential data needed to help make informed policy decisions.
- CDC supports activities of the American Academy of Pediatrics to increase the awareness and involvement of physicians with newborn hearing screening and intervention programs. These activities include providing educational opportunities to primary care providers; assisting state coordinators to access hospitals, individual physicians and other state agencies; providing medical expertise; and reviewing educational materials for providers and parents.
- The Heart Health Matters for Duchenne and Becker muscular dystrophy (DBMD) project: CDC and researchers continue activities of collecting information about the preventive cardiac health care knowledge, beliefs, and behaviors of women who may carry a genetic change for DBMD. This information will help to identify facilitators and barriers that influence preventive cardiac behaviors among female carriers of DBMD, and create successful strategies to increase positive health care behaviors among these women. Activities in this program are being carried out in three different phases. Phase I consists of a qualitative research project involving women who may be carriers for DBMD and their healthcare providers. Phase II involves a nationwide survey of DBMD carriers. Phase III involves development of preliminary communication strategies to increase preventive cardiac health behaviors among DBMD carriers using information gained from earlier phases.
- MD STARnet: CDC is working with partners to develop a population based surveillance program, which is used to describe cases of DBMD within participating states. Currently states participating in MD STARnet include Iowa, Western New York, Colorado, Arizona and Georgia. CDC's goal is to expand MD STARnet to other states in order to achieve a nationally-representative study population. Information gathered through MD STARnet is used to characterize incidence and prevalence of DBMD, types of care offered to patients and the needs of DBMD patients. Information gathered in the MD STARnet process is evaluated and observations will be used to establish baseline information about DBMD. Findings will be published in suitable peer review journals. In addition, the work of MD STARnet will also be made available via fact sheets, web sites, newsletters (to be determined) to patients, patient families, providers and caregivers to convey the status and findings of current research projects using MD STARnet data.
- Early screening and diagnosis of Duchenne muscular dystrophy: CDC funds two research projects (Columbus Children's Research Institute and Emory University) to gather more information on issues identified by the Newborn Screening for Duchenne Muscular Dystrophy Workgroup related to newborn and infant screening for DMD. Through the use of four surveys, the two groups will study issues such as: 1) How well the informed consent process works, 2) Reasons why parents decline screening, 3) Problems after receiving a false-positive result, 4) Families' experiences with the screening programs and their attitudes and opinions about early screening for DMD and, 5) Healthcare providers' attitudes and opinions about the screening programs.
- Attention-Deficit/Hyperactivity Disorder (ADHD): CDC continues to conduct community-based research on ADHD, including population-based studies of prevalence, risk factors, coexisting conditions, and community treatment in collaboration with the University of Oklahoma and the University of South Carolina. CDC collaborates with Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD), a national advocacy organization, to support the National Resource Center (NRC) on ADHD. The NRC is the first and only national clearinghouse and information resource center dedicated to sharing evidence-based science and treatment information about ADHD with the public and to professionals. CDC continues to implement "Attention-Deficit/Hyperactivity Disorder: A Public Health Research Agenda." CDC provided funding to the University of Oklahoma Health Sciences Center and University of South Carolina to study the long-term outcomes and health status of children with ADHD identified and treated in community settings by systematically following up on the subjects who participated in the initial Project to Learn about ADHD in

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Youth (PLAY) study. The PLAY study will allow CDC to address the imminent public health concerns around ADHD diagnosis and treatment as well as better understand and promote the health status of youth with ADHD. CDC is working in collaboration with the American Association of Pediatrics to update diagnostic guidelines for ADHD.

- Tourette Syndrome (TS): CDC partners with the Tourette Syndrome Association (TSA) in support of Tourette Syndrome education and outreach to service providers and the public. Through this cooperative agreement, CDC works with TSA to bolster provider education and intensive training for health care professionals on how to identify, diagnosis, and treat TS. To further understand the prevalence, risk factors, and co-morbidities of TS, CDC collaborated with investigators from the University of Oklahoma Health Sciences Center to initiate a pilot epidemiology study of TS and tics in school-age children. Results from this study are expected in early 2007. Additionally, CDC is supporting extramural research that will identify factors contributing to the quality of life of persons with TS.
- Legacy for Children™ is an ongoing research program to decrease developmental delays or problems in children at-risk for poor developmental outcomes. This set of long-term, randomized studies examines the potential for improving child health and well-being through programs designed to influence parenting behavior. Legacy for Children™ works with low-income mothers to increase: 1) their belief that they can have a positive impact on their child's development (using parent groups to facilitate positive parenting behaviors) and, 2) the amount of time and energy these women invest in their child's development. The study is fully implemented and ongoing in the Miami and Los Angeles metropolitan areas.
- Developmental Health: To improve the practice of developmental screening, CDC established the following goals to help children reach their full potential: 1) Develop and test community-based model programs in primary care settings (and potentially other settings that care for young children) to screen children early and to refer them for further assessment and intervention as appropriate; 2) Increase provider's knowledge of and skills in developmental screening; 3) Monitor use of developmental screening in primary settings; and 4) Raise awareness about the need for and benefits of developmental screening.
- CDC maintains the Universal Data Collection system (UDC) to monitor blood safety and conduct research on health-care outcomes for persons with bleeding disorders.
- CDC performs epidemiology and laboratory research to develop new prevention techniques to lessen the impact of bleeding and clotting disorders as well as other inherited blood cell diseases.

**Significant Accomplishments**

- CDC recently published national prevalence estimates and race/ethnic variation for 21 selected major birth defects using population-based birth defects surveillance data. These estimates are important to 1) plan for health-care and education needs of the U.S. population, 2) identify increased occurrences of birth defects in specific geographic regions by making comparisons between local and national prevalence estimates, 3) serve as a reference point for assessment of state surveillance systems, 4) evaluate national public health interventions, such as folic acid fortification of cereal and grain products, 5) compare U.S. prevalence estimates with those of other countries, and 6) help determine the appropriate allocation of resources for basic and public health research.
- In June 2006, CDC published a study regarding the survival of infants with Down syndrome. Despite an overall increase in survival, the study showed continued racial disparities among children with Down syndrome. By age 20, African-Americans with this condition are more than seven times more likely to die than whites. Improved survival of individuals with Down syndrome has important implications for medical, residential, social and community services systems. More research is needed to understand the causes of and possible solutions to the persistent racial health disparity in survival of individuals with Down syndrome.
- Through the National Birth Defects Prevention Study (NBDPS), thousands of maternal interviews have been conducted. CDC has established a state-of-the-art central biologics laboratory for processing and long-term storage of DNA samples for genetic and gene-environment research studies; developed a comprehensive research agenda using NBDPS data with over 200 projects; and released an analytic database that included calculated variables to improve consistency and quality of analyses across centers. These activities have helped CDC develop capacity to respond to public health concerns and to critically analyze potential risk factors such as maternal smoking, fertility treatments, and the use of medications such loratadine or herbal products.
- In April 2006, CDC in collaboration with more than 35 federal, public and private partners released national recommendations for preconception health and preconception care to improve the health of babies and mothers in its journal Morbidity and Mortality Weekly Report (MMWR) Recommendations and Reports.

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These recommendations, the result of a two-year collaborative effort, identify more than a dozen risk factors and conditions that require interventions before pregnancy to be effective. The recommendations also provide physicians and other health care professionals with the knowledge and tools to act on the scientific evidence that exists about how and when to intervene for preconception care. The U.S. ranks 26th in the developed world in infant mortality. If implemented, the recommendations will help improve the health of babies and moms.

- Based on expert stillbirth workshops held in 2005, CDC has expanded its birth defects monitoring program to include stillbirths.
- The 2006 Congenital Malformations Surveillance Report—a compendium of birth defects prevalence data by state—was published in November 2006. This report, a collaboration of CDC-funded birth defects surveillance programs and the National Birth Defects Prevention Network, provides critical state-specific data on rates and trends of birth defects in the U.S. The report also includes critical analyses of these data.
- CDC published studies utilizing collaborative data from those programs participating in the National Birth Defects Prevention Study, one of the largest studies on the causes of birth defects ever conducted. CDC is currently prioritizing publication of findings related to exposures with high potential impact such as smoking, obesity, and maternal medications. Two studies assessed maternal smoking and maternal progestin exposure as potential risk factors for the birth defect hypospadias. A third paper described the frequency of an emerging and important exposure during pregnancy – over-the-counter medications. In addition, CDC recently published study findings regarding the role of nutrition on the occurrence of cleft defects. The study found that a number of nutritional factors appear to have a link, but more research is needed to elucidate the nature of any associations.
- CDC worked with experts from the state and federal level and private, non-profit organizations to develop a national research agenda for orofacial clefts. The agenda will guide the community to work in concert on their public health research efforts. CDC is currently planning to develop a similar research agenda with respect to other common types of craniofacial malformations, including craniosynostosis.
- A study was recently published with race-specific rates of the birth defects spina bifida and anencephaly prior to and following fortification of U.S. cereal grains with folic acid. The prevalence of these birth defects decreased after fortification among all racial and ethnic groups. However, the data also revealed that the prevalence of these defects remains highest among Hispanics. More studies are required to determine why this is the case and to identify and implement effective strategies to increase folic acid intake specifically among Hispanic women of childbearing age. In addition to ongoing folic acid education efforts targeting Hispanic women, CDC staff are working with partners to explore the feasibility of additional systems-level changes, such as working with manufacturers to increase availability of products fortified with folic acid.
- CDC and the American College of Obstetricians and Gynecologists collaborated to develop “Drinking and Reproductive Health: A Fetal Alcohol Spectrum Disorders Prevention Tool Kit.” With information on screening, education, and counseling, this publication will help women’s health care clinicians prevent FASDs when they encounter risky drinking, regardless of pregnancy status. The free tool kit is being disseminated and is available at no charge to women’s health care providers.
- In December 2006, CDC published a randomized controlled study of the effectiveness of motivational counseling in reducing women’s risk of drinking during pregnancy. The study included a diverse sample of high-risk women. Women in these settings were shown in previous CDC studies to be six times more likely to be at risk for drinking during pregnancy than the general population. The study found that women who received the motivational counseling were twice as likely to reduce their risky drinking compared with those who didn’t receive it.
- In May 2005, an autism study funded in part by CDC was published. The study, conducted in Denmark, showed that both adverse events in pregnancy and parental history of psychiatric illness increased the risk for autism. Epidemiologic studies supported by CDC – such as this one – and the upcoming multi-site collaborative study being launched this spring by CDC and its partner Centers for Autism and Developmental Disabilities Research and Epidemiology, address a critical missing component in autism research: large, representative population-based studies that can answer multiple, high-priority questions needed to determine the causes of autism, and to develop prevention strategies for this complex disorder.
- In April 2006, CDC published a study addressing the time between first evaluation and first autism diagnosis. Early identification of young children with an autism spectrum disorder (ASD) can lead to participation in interventions that support improved developmental outcomes. This important study illuminated the lack of use of standardized diagnostic tools and instruments by practitioners and highlighted

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the need to train both parents and professionals on the early detection of ASD and the importance of early intervention for children with ASDs.

- CDC has taken an active role in promoting early screening and intervention for children with autism. This is the cornerstone message of CDC's current campaign, "Learn the Signs. Act Early" designed for parents, health care professionals, and child care providers. To date the campaign has reached over five million healthcare professionals, distributed over 35,000 professional resource kits and reached every state and U.S. territory. Over 45,000 parent information kits have been distributed; the campaign website has received over 460,000 unique visitors and 1,424,000 page views; more than 93,000 materials have been downloaded; and the call center has received over 25,000 calls. The child care provider phase of the campaign was launched in Fall 2006, and has already been a huge success with this important audience. Since its inception, the campaign has garnered more than a dozen national communication and marketing awards for addressing this important health issue with exemplary professional skills, creativity, and resourcefulness while incorporating sound research, planning, execution, and evaluation.
- In May 2006, CDC published the first study of parental report of diagnosed autism in children aged 4-17 years in the U.S. The study utilized data from the National Health Interview Survey (NHIS) and the National Survey of Children's Health (NSCH). Together, the two surveys of parents suggest that over 300,000 school-aged children had autism in 2003-2004. Population-based surveys such as the NHIS and NSCH might be useful in the future to assess the impact of an autism diagnosis on the child and family. This is one of several methods CDC is using to determine how common autism is in the U.S. and complements CDC's tracking of autism in metropolitan Atlanta and other sites across the U.S.
- CDC announced the funding of three states to develop methodologies to determine the prevalence of ASDs in early childhood and young adult populations. The project will enhance methodologies for identification of ASDs and serve as a prototype for other developmental disabilities. Although previous studies have determined that peak prevalence is best determined by sampling children aged 8, there is great interest in understanding the prevalence of ASD at young ages and in older adolescent and young adult populations.
- In 2006, CDC expanded its webpage spotlights to include cerebral palsy and vision loss in children. Cerebral palsy is a serious developmental disability affecting 1 of every 323 school-aged children. Vision loss is also a serious developmental disability, affecting 1 of every 715 school-aged children. The webpage spotlights provide parents, health care professionals and the public an easily accessible source of reliable information on the prevalence, known causes and research efforts into these serious conditions.
- The Heart Health Matters for Duchenne and Becker muscular dystrophy (DBMD) project: Phase I: Key informant interviews and focus group discussions, part of the qualitative research in Phase I, were completed and analyzed in November 2005. Phase II activities involving the development of a nation-wide survey of DBMD carriers was administered in June 2006 and the results will be analyzed by Spring 2007.
- Early screening and diagnosis of Duchenne muscular dystrophy: To date protocols for the pilot studies have been submitted and are expecting to begin the pilots in January 2007. Validation studies on the total CK by testing 30,000 anonymous newborn bloodspots has been conducted by Ohio Department of Health. Utah has validated DMD genetic testing on bloodspots. In addition, Emory has completed optimization of total CK and genetic testing from bloodspots.
- An update on the investigation of the incidence and associated risk factors of bacterial meningitis among children with cochlear implants was published by Pediatrics in January 2006.
- CDC, in collaboration with the Marion Downs Hearing Center, conducted a National Workshop on Mild and Unilateral Hearing Loss to review and discuss current information related to the identification and appropriate intervention for children with mild and unilateral hearing loss. Participants included more than 50 national and international experts representing the areas of research, clinical practice, early intervention, parent and national organizations, and state and federal agencies. CDC published the Workshop Proceedings of the National Workshop in 2006 and expects to publish recommendations on mild and unilateral hearing loss in the coming months.
- CDC's epidemiological study on ADHD has strengthened the agency's surveillance activities by screening approximately 10,500 children between 5 and 10 years of age. This is the largest epidemiologic study to date to examine rates of co-morbidities and frequency of risk and protective behaviors in a population-based sample of youth known to have ADHD. The NRC continues to promote the health and well-being of children and adults with ADHD by providing evidence-based information, fielding over 12,000 inquiries and 1.1 million hits on the website, [www.help4adhd.org](http://www.help4adhd.org), per year. CDC has produced multiple publications, including "Prevalence of Diagnosis and Medication Treatment for Attention-Deficit/Hyperactivity Disorder — United States, 2003" which is the first national and state-specific estimates of medication treatment for

ADHD, and represents a critical step of evaluating the impact of the condition on children, families, and the health system. In addition, CDC published "Attention-Deficit/Hyperactivity Disorder in School-Aged Children: Association With Maternal Mental Health and Use of Health Care Resources" to understand the association between the mental health status of mothers and ADHD in their school-aged children and to characterize the health care access and utilization of families affected by ADHD.

- Strengthened surveillance activities by screening approximately 7,000 students for Tourette Syndrome between the ages of 5 and 10 years of age. Pilot surveillance findings suggest that approximately two percent of elementary-aged youth experience chronic tics. Through education and outreach efforts, CDC trained over 3,000 professionals to increase recognition and diagnosis of TS, the provision of and improving the nature of treatments and academic outcomes for children with TS. Additionally, professionals were trained to decrease the stigma attached to the disorder and negative impacts on families. As a result of CDC's participation on the Technical Expert Panel for the National Survey of Child Health, all of the top five children's mental health conditions, including TS, were included in this nationally representative survey. This will allow for generating national and state-based prevalence rates for most of these conditions as well as allow for a national prevalence estimate of TS and tic disorders.
- Legacy for Children™: To date, CDC convened 2,522 weekly parent group meetings (1,625 in Miami and 897 in UCLA) and conducted over 1,400 developmental assessments, resulting in early identification and referral of over 6.5 percent of one-year olds with mild to significant developmental delays. This helped ensure that these children were receiving appropriate interventions in a timely fashion. In addition, results from a current survey revealed that 96 percent of parents are satisfied with Legacy.
- Developmental Health. CDC collaborated with several key partners to develop a statement on "Promoting Social, Emotional and Developmental Health in Children and Youth: A Public Health Strategy." This document presents a comprehensive strategic framework to be used by policy makers, health care professionals, educators, public health agencies, juvenile justice, child welfare, foundations, family health advocacy groups, public and private health insurers, and families to promote child and adolescent development. The application of recommendations in this statement will support and promote many of the goals and objectives of the Individuals with Disabilities Education Act, the U.S. Department of Health and Human Services' Healthy People 2010, the President's New Freedom Commission on Mental Health, and School Readiness initiatives. CDC funded 15 pilot projects in collaboration with the American Academy of Pediatrics to improve the practice of developmental screening. Published "Improving Women's Health during Internatal Periods: Developing an Evidenced-Based Approach to Addressing Maternal Depression in Pediatric Settings" in the Journal of Women's Health (July/August 2006) to highlight the important role pediatric providers can undertake to improve women's health in the internatal period through the detection and management of maternal depression at well-child visits. Established and maintained a developmental screening website (<http://www.cdc.gov/hcbddd/child/devtool.htm>).
- CDC, in partnership with the Institute of Medicine, sponsored a workshop to provide an update on the current knowledge of disability issues. The proceedings of the workshop are published in Workshop on Disability in America: A New Look, which is a review of current conceptual frameworks in disability research as well as demographic trends among children, working age adults, and older adults. The dissemination of this volume is providing critical updates to a wide audience on disability research.
- CDC published the first ever Chartbook on the health of people with disabilities. The Chartbook provides state by state information.
- CDC grantees, in collaboration with the Christopher and Dana Reeve Paralysis Resource Center, published "Developing an Action Plan to Improve the Quality and the Quantity of Paralysis Data" which summarized the current data available on persons with paralysis in the U.S.
- In 2006, CDC expanded its collaboration with hemophilia treatment centers to develop a uniform electronic data collection system to collect information for surveillance as well as a future clinical research database for patients with bleeding disorders.
- In 2006, CDC conducted a Joint Outcome Study – a randomized clinical trial found that prophylaxis prevents joint disease in young boys with hemophilia. In a related effort involving a study of uniform data collection joint data, body mass index was found to be strongly associated with joint range of motion loss in hemophilia patients under 20 years old.

**NARRATIVE BY ACTIVITY**  
**HEALTH PROMOTION**  
**BIRTH DEFECTS, DEVELOPMENTAL DISABILITIES, DISABILITY AND HEALTH**

**OUTPUT TABLE**

OUTPUT TABLE	FY 2006 ACTUAL	FY 2007 CR	FY 2008 BUDGET	FY 2008 +/- FY 2007
Prevent or Reduce Birth Defects and Developmental Disabilities				
Programs funded for birth defects surveillance and prevention research	15	15	15	0
CDC projects to develop, test, and distribute educational messages for the folic acid campaign	4	4	4	0
FAS prevention state capacity programs	8	8	8	0
Programs to develop effective interventions with children with FAS	5	5	5	0
Number of states participating in research on Autism and Other Developmental Disabilities	6	6	6	0
Number of states conducting monitoring for autism and other developmental disabilities	10	10	10	0
Improve the Health and Development of all People with Disabilities or Potentially Disabling Conditions				
Disability Research Grants	7	7	7	0
Disability State Capacity Grants	16	16	16	0
Disability and Health Information Centers	3	3	3	0
National Spina Bifida Program Research projects	4	4	4	0
State tracking program for Early Hearing Detection and Intervention	35	35	35	0
Research projects for Early Hearing Detection and Intervention	11	11	11	0
States conducting surveillance for DBMD	6	6	6	0
State Research projects for DBMD	5	5	5	0
Attention Deficit Hyperactivity Disorder projects (includes resource center)	3	3	3	0
Hemophilia/ Thalassemia Treatment Centers	140	140	140	0

NARRATIVE BY ACTIVITY  
HEALTH PROMOTION  
BIRTH DEFECTS, DEVELOPMENTAL DISABILITIES, DISABILITY AND HEALTH

OUTPUT TABLE	FY 2006 ACTUAL	FY 2007 CR	FY 2008 BUDGET	FY 2008 +/- FY 2007
Hemostasis/ Thrombosis Pilot Sites	8	8	8	0
Percentage of persons with hemophilia being seen at a HTC who also participate in CDC's UDC blood safety monitoring program.	90%	90%	90%	0

**FUNCTIONAL TABLE**

BIRTH DEFECTS, DEVELOPMENTAL DISABILITIES, DISABILITY AND HEALTH (DOLLARS IN THOUSANDS)	FY 2006 ACTUAL	FY 2007 CR	FY 2008 BUDGET	FY 2008 +/- FY 2007
Birth Defects and Developmental Disabilities	\$38,458	\$38,484	\$38,484	\$0
Human Development and Disability	\$65,898	\$65,944	\$65,944	\$0
Hereditary Blood Disorders	\$20,095	\$20,109	\$20,109	\$0
Total	<b>\$124,451</b>	<b>\$124,537</b>	<b>\$124,537</b>	<b>\$0</b>

## HEALTH INFORMATION AND SERVICE

HEALTH INFORMATION AND SERVICE (DOLLARS IN THOUSANDS)	FY 2006 ACTUAL	FY 2007 CR	FY 2008 BUDGET	FY 2008 +/- FY 2007
BA	\$84,670	\$84,731	\$108,361	\$23,630
PHS Evaluation Transfers	\$134,235	\$134,235	\$135,135	\$900
Total	<b>\$218,905</b>	<b>\$218,966</b>	<b>\$243,496</b>	<b>\$24,530</b>

### **INTRODUCTION**

The Health Information and Service budget activity is responsible for assuring that CDC provides the highest-quality information, programs, and services in the most effective ways to help people, families, and communities protect their health and safety. For the first time in CDC's history, a unique set of functions and activities have been combined to help the agency reach out more effectively to the public and improve health impact. CDC's charge from the greater public health community and the nation is that of service in acquiring, evaluating and conveying science-based public health information. CDC provides this leadership through public health informatics, vital and health statistics, health marketing and communications. The large array of services that are provided to hundreds of public and private health officials across the nation and the world include training, tools, resources, standards, guidelines, scientific/technical/programmatic assistance and data sharing.

#### **Health Statistics – Delivering up-to-the-minute health statistics and data to guide and evaluate public health policy and public health program development.**

Through vital and health statistical data CDC guides public health interventions and policies that improve the health of all Americans and impacts the lives of people around the world. CDC collects data from birth and death records, medical records, interview surveys, and through direct physical exams and laboratory testing. These data are used to identify disparities in health status and health care access by race/ethnicity, socio-economic status, region and other population characteristics so that corrective public health action can be taken. This rich source of health data and statistical service truly sets the foundation for our national public health efforts.

#### **Public Health Informatics – Using state of the art information science to gather, process, store, protect, and communicate public health information and making certain that these data are made useful to both the public health community and the nation as a whole.**

CDC applies the power of information and state of the art computer science and technology to gather and manage the vast wealth of information which will ultimately be required by and inform CDC programs and health policies worldwide. CDC must continue to be the world's leader in acquiring, understanding, and disseminating public health information. Public health informatics helps to address the need for urgent information in "real-time." In an outbreak, meaningful, relevant health data must be shared in seconds—not hours or days--among researchers, public health officials, and clinicians who are separated by thousands of miles. An increasingly sophisticated public with both the need and the desire for instant access to reliable, trustworthy health information relies on CDC for knowledge that will allow everyone to better manage, control and improve their health. The modern discipline of informatics greatly improves our ability to respond immediately with the right information, bridging urgent health needs with timely health data.

#### **Health Marketing – Communication and health marketing are vital tools for bridging the gap between science and effective interventions and ensuring people have and use accessible, accurate, relevant and timely health information and interventions to protect and promote their health and the health of their families and communities.**

Through health marketing and communications CDC provides customer-centered and science-based strategies for creating, communicating and delivering health information to protect and promote the health of diverse populations. Some of the signature programs include CDC's *Morbidity and Mortality Weekly Report*, the Emergency Communication System of the CDC Emergency Operations Center, the Guide to Community Preventive Services, CDC's website (<http://www.CDC.gov>), and coordination of CDC's public and private partnerships. In addition to its traditional partner organizations in public health, CDC has identified and is currently working with partners from business, faith and other community groups, health care, education, and other sectors of society to assure maximum outreach and effectiveness of its programs. In our outreach to partners, CDC builds relationships that incorporate shared learning, mutual trust, and diversity in points of view and sectors of society. Through continuous consumer input, prevention-related research, and public health information technology, CDC identifies and evaluates health needs and interests, translates science into actions to meet those needs, and engages its partners in improving the health of the nation.

## HEALTH STATISTICS

### AUTHORIZING LEGISLATION

PHSA §§ 301, 304, 306<sup>1</sup> 307, 308 1% Evaluation: PHSA § 241 (non-add) (Superseded in the FY 2002 Labor HHS Appropriations Act - Section 206)

HEALTH STATISTICS (DOLLARS IN THOUSANDS)	FY 2006 ACTUAL	FY 2007 CR	FY 2008 BUDGET	FY 2008 +/- FY 2007
PHS Evaluation Transfers	\$109,021	\$109,021	\$109,921	\$900

### STATEMENT OF THE BUDGET

The FY 2008 Budget of \$109,921,000 for Health Statistics reflects an increase of \$900,000 above the FY 2007 Continuing Resolution 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 Health Statistics highlighted performance goal is to monitor the nation's health through high-quality data systems.

CDC's health statistics activities provide critical data that represent the society's health in various areas. Statistics inform the public about current public health challenges and provide a foundation for understanding existing health problems. Health statistics are used to recognize emerging trends (e.g. obesity), to create a basis for comparisons between population groups or geographic areas, to identify health disparities and target action, and to understand how trends in health change and develop over time.

Health statistics guide national policy and support public programs and goals. Current health information is needed in all sectors of society as a prerequisite for linking risk behavior to health outcomes, targeting health messages, and planning and evaluating programs that can lead to improvements in health and quality of life.

Statistics make government accountable. Health statistics are used to monitor CDC's effectiveness in addressing public health concerns. These data are used to formulate strategic plans, monitor performance and monitor progress on national goals.

CDC's health statistics surveys serve the needs of a broad range of programs, researchers, and policy makers in CDC, HHS, and across the health community. They are based on sound statistical methods and are conducted in an open, independent, and objective manner. Maintaining and building on HHS' existing data systems are important from a management standpoint, as these systems are more efficient than launching multiple independent systems to meet individual agency information needs.

Investments in CDC health statistics systems are critical to advancing CDC's 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.

### RATIONALE FOR THE BUDGET

The FY 2008 Budget of \$109,921,000 for Health Statistics reflects an increase of \$900,000 above the FY 2007 Continuing Resolution of \$109,021,000.

#### National Home and Hospice Care Survey (NHHCS) (+\$0.9 million)

Increased funding in FY 2008 will be used for fielding the redesigned NHHCS, the first since 2000. The NHHCS is a continuing series of surveys of home and hospice care agencies in the United States. Information was collected about agencies that provide home and hospice care and about their current patients and discharges. The NHHCS is based on a probability sample of home health agencies and hospices. The survey includes all agencies that are licensed or certified (Medicare or Medicaid). Data are collected through personal interviews with administrators and staff on referral and length of service, diagnoses, number of visits, patient charges, health status, reason for discharge, and type of services provided.

## **PERFORMANCE ANALYSIS**

### **PART Results**

Ongoing actions to improve performance as a result of the National Center for Health Statistics 2005 PART review include conducting independent project evaluations and tying the program budget to performance. Through use of CDC's agency-wide budget and performance software system, the center continues to track project budgets, performance, and outcomes. Use of the system will continue and evolve as additional needs arise. Independent evaluations will follow several focus groups and completed survey instruments. Analysis is ongoing and results are expected at the end of calendar year 2006. Analyses will provide insight on the progress of achieving new long-term measures and program improvements.

### **Current Activities**

#### National Health and Nutrition Examination Survey (NHANES):

- Collect information annually on health status obtained through personal interviews with standardized physical and dental examinations, diagnostic procedures, and lab tests.
- Maintain continuous field operations on a nationally representative sample of 5,000 individuals at 15 U.S. sites.
- Address priority population groups and issues through efforts to over sample African-Americans, Mexican-Americans, adolescents, persons over 60 years of age, pregnant women, and low-income whites.
- Collaborate with other federal agencies to address specific research and program-driven needs on areas such as oral health, body composition, food activity, lower extremity disease, mental health, vision, diabetes, diet, and nutrition, and balance these program-specific needs with broad health topics of continuing importance.
- Serve as the data collection mechanism to monitor diet and nutritional status of Americans by providing information needed for food policy and dietary guidelines.
- 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.

#### National Vital Statistics System (NVSS):

- Provide the nation's official vital statistics data based on the collection and registration of birth and death events at the state and local level.
- Work with federal and state partners on development of minimum standards for birth certificates and the issuance of birth certificates in compliance with the Intelligence Reform and Terrorism Prevention Act (IRTPA), Section 7211.
- Work with states on the implementation of a Web-based system for collection of statistics including implementation of content revisions of the U.S. Standard Certificates of Live Birth, Death and Fetal Death.
- Assist states in the development of systems specifications for their new registration systems based on the use case models developed by Social Security Administration (SSA), the National Association for Public Health Statistics and Information Systems (NAPHSIS), and CDC.
- Provide data to monitor key national indicators, including reductions in teen pregnancies, low birth weight and preterm birth, and maternal risk factors including smoking during pregnancy, hypertension, and anemia.

#### National Health Interview Survey (NHIS):

- Provide information annually on the health status of the U.S. civilian non-institutionalized population through confidential interviews conducted in households.
- Publish data on a quarterly basis on lack of health insurance coverage to reflect different policy-relevant perspectives on persons with access to care. The data provide three fundamental measures of health insurance coverage at the time of interview: 1) persons who currently lack coverage; 2) the estimate of persons who were uninsured at any time in the past year; and 3) the measure of lack of coverage for more than one year. These measures are released six months after collection.
- Collect and publish data on a quarterly basis on selected health measures of health status and disability, access to care, use of health services, immunizations, health behaviors, ability to perform daily activities, and child mental health.

NARRATIVE BY ACTIVITY  
HEALTH INFORMATION AND SERVICE  
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- Design and implement a new sample for the NHIS to ensure it accurately reflects the shifting U.S. population demographics identified in the decennial census and refocus surveys on population groups that are growing.

National Health Care Survey (NHCS):

- Provide an overview of how hospitals, emergency and outpatient departments, ambulatory surgery centers, nursing homes, hospices, and office-based physicians deliver health care.
- Released public-use data files for the 2004 National Nursing Home Survey (NNHS). This survey includes an increased sample size, expanded clinical content, new information on staffing and turnover, data on facility policies and practices, and the use of computer-assisted personal interviewing. The NNHS includes the first-ever nationwide survey of nursing assistants.
- Increase the utility of the National Ambulatory Care Medical Care Survey and the National Hospital Ambulatory Medical Care Survey (NHAMCS) by increasing the number of participating providers. In addition, in the 2007 NHAMCS, there are questions asking whether hospital receive funds for bioterrorism preparedness, participation in internal drills, and scenario of drills.
- Implement new methods and technology to better reflect the changing distribution of the population and changes in the mix and range of health care providers to take advantage of existing record systems, particularly electronic systems, and to incorporate a wider range of data items such as prescription drugs and clinical quality measures.
- Conduct the National Survey of Ambulatory Surgery (the survey has not been conducted since 1996) that will complement the National Hospital Discharge Survey which focuses on inpatient care. The survey will allow CDC to provide more comprehensive data on surgical procedures, many of which have moved from inpatient to outpatient settings.

Significant Accomplishments

- Results from NHANES indicate that between 1988-94 and 2003-2004, the number of overweight children and adolescents between 12 and 19 years of age increased from 11 to 17 percent; the number of overweight children six to eleven years of age increased from 11 to 19 percent during the same period. The number of overweight and obese adults 20 years of age and older increased from 56 percent to 66 percent during the same time period; almost five percent of adults in 2003-2004 were extremely obese.
- Data such as overweight prevalence and increased calorie consumption document the country's epidemic of overweight and obesity and are used to illustrate the percentage of Americans at elevated risk of a variety of health problems. The release and publication of these data resulted in the DHHS 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 they eat. The data led to legislative initiatives and changes in messages and food choices from the food industry. The data are useful in national nutrition program planning efforts and in the development and evaluation of nutrition policies.
- Data provide answers for researchers and nutritionists and are used as the basis for recommendations on food fortification decisions as well as on amount of vitamins and minerals essential for a healthy diet (i.e., iron for women of childbearing age, preschool children, and the elderly).
- Data from the National Survey of Family Growth (NSFG) show that sexual activity declined significantly for younger teenage girls and for teen 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."
- Preliminary 2005 data show the teen birth rate has dropped to its lowest level ever, and dropped 35 percent between 1991 and 2005. Between 2004 and 2005 the teen birth rate dropped 2 percent, from 41.1 to 40.4 per 1,000 females 15 to 19 years of age. Tracking these vital statistics is critical to national policy on teen pregnancy prevention and initiatives to reduce out-of-wedlock births.
- Final data for 2004 show life expectancy in the U.S. at birth was 77.8 years for all races, 78.3 years for whites, and 73.3 years for blacks. The infant mortality rate decreased from 6.9 infant deaths per 1,000 live births in 2003 to 6.8 in 2004. These data are crucial for public health officials at the national, state and local level to monitor progress toward achieving health goals related to infant mortality.
- Developed a national consensus document 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

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HEALTH INFORMATION AND SERVICE  
HEALTH STATISTICS

software that can greatly accelerate timeliness and quality of vital statistics. Phase 1 requirements for the model vital statistics system are complete and now publicly available. The state of Georgia is in the process of developing a new electronic birth system based on these requirements, and New York City is also developing a re-engineered death registration system based on the model requirements.

- Submitted draft regulations in response to the IRTPA Section 7211 to the Department and OMB. The IRTPA requires improvement in the security of birth certificates through the development of minimum standards for birth certificates and the issuance of birth certificates, which can be achieved through implementation of electronic birth, death, and linkage systems.
- 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. Trend data from the 2005 NHIS were released in June 2006. The microdata release occurred one month earlier than last year's release. Future annual releases of the NHIS data are scheduled to be made only six months after data collection is completed.
- Collaborated with NIH and in June 2004 published the Complementary and Alternative Medicine Use Among Adults. The survey included questions on 27 types of CAM therapies commonly used in the U.S., including 10 types of provider-based therapies, and 17 other therapies that do not require a provider. Due to the success of this collaboration, the survey will be conducted again in 2007. The report showed that 36 percent of U.S. adults aged 18 years and over use some form of CAM. When the definition of CAM is expanded to include prayer specifically for health reasons, the number of U.S. adults using some form of CAM increases to 62 percent.
- Data are used by public health officials to gain a more complete understanding of the uninsured population, those with less access to care and those less likely to be receiving preventive services, and by policy makers to show the proportion of the population that lack coverage and to understand the shifts in coverage from private to public sources (such as SCHIP and Medicaid). Data from January to June 2006 show the percentage of uninsured persons at the time of the interview was 19.2 percent for persons aged 18 to 64 years and 9.2 percent for children under age 18. A total of 53.0 million persons (18.1 percent) of all ages had been uninsured for at least part of the year prior to the interview.
- Data are used to examine prescribing practices for medications as well as patient safety issues such as the extent to which complications, injuries or adverse effects result from medical treatment. During 2004, there were an estimated 1.8 million visits to emergency departments (EDs) in the U.S. for adverse effects of medical treatment (including 1.1 million visits for medical and surgical complications and .7 million for adverse effects of medications). These injuries comprised 4.4 percent of all injury-related ED visits during 2004.
- Data are used to document hospitals' readiness for treating patients from terrorism attacks and mass casualty incidents. Preliminary data from 2003 to 2004 show that the vast majority (92 percent) of hospitals had revised their written plans for responding to natural disasters and terrorism attacks since 2001, and about the same percentage (88 percent) had conducted mass casualty drills with outside organizations. However, formal patient transfer arrangements (52 percent) lagged behind cooperative planning with other hospitals (79 percent). Drills that included hazardous materials teams (43 percent) lagged behind drills that included emergency medical services (74 percent) and fire departments (70 percent).
- Data on the diffusion of health information technology in ambulatory settings indicate that one-quarter of office-based physicians report using fully or partially electronic medical record systems in 2005, a 31 percent increase from the 18.2 percent reported in 2001. Patient safety advocates emphasize the need for health care organizations to implement process and system-level changes to decrease opportunities for error, and NCHS data can be used to track such practice changes.
- Data are used to show public health officials at the national, state, and local levels 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 2004, an increase of 18 percent over the 93.4 million visits made in 1994.

**OUTPUT TABLE**

OUTPUT TABLE	FY 2006 ACTUAL	FY 2007 CR	FY 2008 BUDGET	FY 2008 +/ FY 2007
Monitor Trends in the Nation's Health through High-quality Data Systems Addressing Issues Relevant to Policymakers				
Number of key elements of the health care system for which data are collected	3	3	3	0
Number of communities visited by mobile examination centers from the National Health and Nutrition Examination Survey	15	15	15	0
Data systems for which significant efforts will be underway for redesign, reengineering, or transformation <sup>1</sup>	3	3	2	(1)
Number of households interviewed in the National Health Interview Survey	35,000	35,000	35,000	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

<sup>1</sup> The NHIS redesign will be complete by 2008, reducing the number from 3 to 2.

## PUBLIC HEALTH INFORMATICS

### AUTHORIZING LEGISLATION

PHSA §§ 301, 304, 306<sup>1</sup>, 308, 307, 310, 311, 317<sup>3</sup>, 318<sup>1</sup>, 319, 319A<sup>4</sup>, 319B<sup>1</sup>, 319C<sup>4</sup>, 327, 352, 391<sup>3</sup>, 1102, 2315, 2341, Clinical Laboratory Improvement Amendments of 1988, § 4

PUBLIC HEALTH INFORMATICS (DOLLARS IN THOUSANDS)	FY 2006 ACTUAL	FY 2007 CR	FY 2008 BUDGET	FY 2008 +/- FY 2007
BA	\$45,490	\$45,521	\$69,651	\$24,130
PHS Evaluation Transfers	\$24,751	\$24,751	\$24,751	\$0
Total	<b>\$70,241</b>	<b>\$70,272</b>	<b>\$94,402</b>	<b>\$24,130</b>

### STATEMENT OF THE BUDGET

The FY 2008 Budget of \$94,402,000 for Public Health Informatics reflects an increase of \$24,130,000 above the FY 2007 Continuing Resolution of \$70,272,000.

### PROGRAM DESCRIPTION

Information systems and information technology (IT) are critical to the practice of public health in the 21st century. Informatics provides new and creative solutions through information systems to address the public's health. Informatics extends the traditional reach of public health professionals; allowing them to make better decisions by providing a more accurate view of public health events. Public health involves collecting, managing, analyzing, and sharing information that drives evidence-based decisions and improves health impact. Public Health Informatics supports these functions and thus, provides new capabilities for preventing diseases, disability and other public health threats to avoid the burden of illness. Public Health Informatics activities further enhance discovery, innovation, and application of public health information and information systems to provide better support for public health preparedness. CDC will continue to strengthen its leadership role in public health informatics policy and standard setting, defining informatics needs nationally, working with other national health information technology activities, and increasing capacities for public health informatics research.

CDC provides national leadership in public health to define and document the functional needs of public health information systems; define the information and technical architectures for public health and ensure integration with other national health IT activities; identify and support industry standards and develop the specifications that implement interoperability; advance the "best of breed" processes and practices for the development and implementation of IT; develop systems and software components where necessary; and advance public health informatics capacities nationally. CDC also elevates public health informatics as a discipline nationally, making it an area of focus across all of public health, especially at the state and local level. Public Health Informatics ensures that the best information systems solutions are available, and that public health professionals and information technologists are fully utilizing the best available information technology solutions.

CDC's Public Health Informatics activities include on-going collaborative efforts to build a national network of public health information systems. These systems will enhance public health partner capabilities in detection and monitoring, surveillance, data analysis and interpretation, information resources and knowledge management, preparedness, communications, and response. Information systems designed to support these areas will integrate to provide state and local public health partners with near real-time access to information that can assist in effectively assessing the health of their community, identify the causes of a disease, provide the tracking and management capabilities necessary in responding to and containing an outbreak, and work to connect public health to the vital clinical care information environment.

### RATIONALE FOR THE BUDGET

The FY 2008 Budget of \$94,402,000 for Public Health Informatics reflects an increase of \$24,130,000 above the FY 2007 Continuing Resolution of \$70,272,000.

#### Pandemic Influenza (+\$24.5 million)

The FY 2008 President's Budget includes funding for Pandemic Influenza Preparedness to support the vaccine registry and the Real Time Assessment and Evaluation of Interventions.

Vaccine Registry (+\$14.6 million)

With funding of \$14.6 million in the FY 2008 President's Budget, CDC will develop a vaccine registry to monitor vaccine use and distribution. The development of a vaccine and antiviral tracking system that includes records of vaccination and the administration of other countermeasures is critical to ensuring that vaccines reach the targeted audience and that antivirals are appropriately administered. CDC will develop and deploy national capabilities to track and manage the distribution of influenza vaccine and other countermeasures through government purchase, stockpile, or commercial purchase from the point of manufacture through the delivery of these vaccines. CDC will also integrate such information with adverse event monitoring and surveillance tracking.

Real Time Assessment and Evaluation of Interventions (+\$9.9 million)

Models can be an effective and efficient means of anticipating problems and needs, but they are heavily dependent on the availability of complete and current data. Current models of the influence of influenza and the evaluation of interventions are almost always based on old data and thus are frequently incomplete. They also do not account for the need to rapidly redistribute scarce resources such as staff, vaccines, equipment, and information systems.

With increased funding in the FY 2008 President's Budget, CDC will improve decision makers' ability to understand the current disease burden, develop predictions, and integrate key surveillance data by enhancing system capabilities in three key ways: 1) collect and collate all suitable existing influenza-related surveillance data from various systems to develop a population-based analysis of disease impact and evaluation of interventions; 2) design and implement robust models that will use these data to provide frequently updated population-based estimates of disease burden and impact of interventions; and 3) create decision tools based on these data and usable by decision makers at local, state, and national levels.

Public Health Information Network (PHIN) (-\$0.4 million)

In FY 2008, CDC will eliminate the development of new requirements and standards related to PHIN. This will reduce contract services for PHIN-related activities which include: facilitating the successful adoption and implementation of PHIN standards; development of a national public health information network by providing information technology expertise, assisting in deployment and adoption of CDC developed PHIN applications and providing guidance in achieving compliance with PHIN standards; integrating existing software applications; and reduced coordination with NHIN, thereby impairing coordination between public health informatics activities and nationwide health information activities.

## **PERFORMANCE ANALYSIS**

Current Activities:

CDC's public health informatics activities support a variety of public health programs at federal, state and local levels.

- PHIN ensures that necessary public health information systems are present and working together at the state, local, and federal levels. Through PHIN, CDC will continue to help state and local public health partners develop informatics solutions using national, industry-based standards and specifications for exchanging data to ensure the nation is prepared in the event of a terrorism attack or other public health emergency.
- The BioSense Initiative focuses on early event detection by connecting electronic health records from hospitals, clinics, and other health-related sources. These records are used for early-detection purposes, the initiation of outbreak management, communications and preparedness, connecting laboratory systems, and countermeasure and response administration. BioSense provides federal, state and local public health professionals with near real-time views of their community's health status at the zip code level.
- With the response to the 2001 Anthrax attacks hindered by ad-hoc systems lacking interoperability, CDC developed the Outbreak Management System (OMS) to enable an effective and rapid response in a public health emergency. OMS meets the Investigation goal of the nine overall CDC Preparedness Goals. OMS supports public health partners by decreasing the time needed to identify causes, risk factors, and appropriate interventions for those affected by threats to the public's health. It provides a suite of tools for capturing analysis-ready outbreak data including demographic, case, and contact data for any entity and agent. It also provides for data sharing and interoperability by means of standardized electronic communications and supports data import, export, and synchronization.
- 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

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information and the electronic informatics applications that facilitate the transmission and reporting of this information, state and local public health agencies or communities can set priorities, take appropriate action to prevent illness, and evaluate the effectiveness of their programs. The National Electronic Disease Surveillance System (NEDSS) is an initiative that promotes the use of data and information system standards to advance the development of efficient, integrated, and interoperable surveillance systems at federal, state, and local levels. A primary goal of NEDSS is the ongoing, automatic capture and analysis of data that is already available electronically, such as laboratory results data, now routinely available from national clinical laboratories.

- Partner Communications and Alerting (PCA) capabilities include the rapid distribution of health alerts, collaborative communications among public health professionals and the broad sharing of information with the public. The management and dissemination of urgent and non-urgent information to public health partners (e.g. state and local public health workers, primary care physicians, public health laboratories, other federal agencies, etc.) can be achieved using multiple channels of distribution, including e-mail and secure Web sites. PCA capabilities will provide real-time access to information, establish alerting protocols, and ensure information remains constantly available regardless of the recipients' locations.
- Countermeasure and Response Administration (CRA) manages the administration of vaccine, prophylaxis, isolation, and quarantine to contain an outbreak, respond to a public health event, and support the allocation of limited supply pharmaceuticals to ensure coverage of high risk population groups. Specifically, CRA enables the coordination and management of pharmaceutical and/or non-pharmaceutical responses and tracks the administration of treatments, prophylaxes, vaccinations, isolation, and quarantine.
- The management of data and test results associated with a public health event can be complex and unsupported by any form of standardized electronic reporting between participating organizations. CDC is developing technology for Connecting Laboratory Systems (CLS) which enables the timely electronic exchange of laboratory results to public health partners, coordinates laboratory services for laboratory testing, and easily links laboratory findings to related epidemiological data that ultimately provides rapid analysis and improved situational awareness. CLS establishes common specifications and processes for information exchange among the nation's laboratories (public health, clinical, and hospital-based) and their partners.
- CDC continues to manage increasing amounts and types of public health information and ensures timely and intuitive access to such data by citizens; federal, state, and local partners; and the internal CDC community. Such access is a critical necessity to achieve the objectives of public health. To meet these needs, CDC has developed a unified knowledge management approach implemented across the agency.
- CDC is working with Federal Health Architecture (FHA) to implement the Consolidated Health Informatics (CHI) standards for reducing the burden of private sector reporting through the automated use of electronic clinical data for public health purposes as an alternative to manual reporting. CDC is also supporting national electronic health record (EHR) activities to ensure public health needs are represented in EHRs and to ensure EHRs and electronic public health systems can work together to improve clinical and public health outcomes.
- As a part of the CDC Research Agenda, Public Health Informatics will be elevated as a discipline nationally, making it an area of focus for expanding public health research capacity across all of public health. The informatics research topic areas include analytical methods, information and data visualization, communications and alerting technologies, decision support, electronic medical records, and knowledge management. Focusing on these areas enables CDC and its partners to define and manage the architecture for public health information systems nationally by establishing the capabilities for federal, state, and local information systems to work together and connect with clinical care and other organizations. These systems provide new and creative solutions to extend the reach of public health, allowing it to achieve more through collecting, analyzing, and sharing data that drive evidence-based decisions with the goal of improving health impact. Public Health Informatics supports these functions and provides new capabilities for preventing and managing diseases and other public health threats to support even greater health impact.

Significant Accomplishments:

- In collaboration with public health partners, refined the requirements and key performance indicators for information systems for the public health. These requirements, will be available for review and comment in January, and then released for publication in the summer of 2007. They have been directed for use at the state and local levels and will be the basis for ensuring that interoperable systems will be in place to support a wide variety of public health activities.

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- Developed message specifications and implementation guides to support reporting from states and larger local jurisdictions for over 100 notifiable conditions; message specifications to support laboratory reporting from clinical and public health laboratories for human and environmental testing, including bioterrorism, to public health; messages and standards for use at the state and local levels for vaccination reporting, smallpox vaccination program and active surveillance reporting; and messages and standards for the exchange of alert information between public health agencies, and other emergency response/emergency management agencies, using the Common Alert Protocol (CAP) as advised by the Office of Management and Budget (OMB) and the Department of Homeland Security (DHS).
- Widely used PHIN standards to transmit public health information used for event detection and routine surveillance reporting. To date, CDC has sent, received and/or processed numerous records from various sources and significantly improved disease reporting times. As state and local health departments begin implementing NEDSS, reports are generated on a daily rather than weekly basis. In 2005, CDC received over 70,000 nationally notifiable disease case reports from sites using the CDC-developed NEDSS-based system.
- CDC published the Summary of Notifiable Diseases, United States for the year 2004. The annual Summary highlights public health surveillance findings collected by 50 states, two autonomous reporting jurisdictions (New York City and Washington, D.C.), and five U.S. Territories. These data are reported to CDC's National Notifiable Diseases Surveillance System (NNDS). Provisional NNDS data were disseminated in tabular and graphical format each week throughout each year in CDC's Morbidity and Mortality Weekly Report (MMWR).
- As part of its national influenza surveillance effort, the CDC receives weekly mortality reports from 122 cities and metropolitan areas within two to three weeks from the date of death. CDC updated the 122 Cities Mortality Reporting System Manual of Procedures and the Quick Guide for weekly reporting of pneumonia and influenza mortality. These materials were distributed to city reporters, State Epidemiologists, and other public health surveillance staff. Pneumonia and influenza mortality data from this system are published each week in the MMWR. Information from this system (and others) provides CDC epidemiologists with preliminary information with which to evaluate the impact of influenza on mortality in the United States.
- BioSense acquired clinical care data from each of 10 BioWatch cities, and an additional two. All participants provided various levels of data which will assist BioSense in the early detection of bioterrorism and natural disease outbreaks. BioSense held a meeting to solicit feedback from external public health partners, data source clinical staff, and researchers. This feedback will be used in the development of the next version of BioSense.
- Countermeasure and Response Administration has developed standardized reports for state and local users to generate when tracking vaccination activity, which will help to establish a consistent tracking mechanism for this process. Investigational Vaccination Administration (IVA) 1.0 has been designed, developed, and deployed. This program supports data collection related to Investigational New Drug (IND) influenza vaccinations. The intent is to modify this program for other needs besides influenza in the future.
- The Outbreak Management System is "live" in Tennessee, Michigan, and California. CDC staff is actively involved in training and installation of the system in Ohio, New York City, Puerto Rico, Miami, Colorado, Seattle-King County, and Vermont.
- The NEDSS Base System is currently "live" in ten states: Nebraska, South Carolina, Tennessee, Texas, Alabama, Oregon, Vermont, Nevada, Virginia, and Idaho. CDC staff is actively involved in training and installation of the system in Arkansas, Maryland, New Mexico, Rhode Island, Maine, Wisconsin, Minnesota, Montana, Wyoming, and New Hampshire.
- Increases in the number, completeness and timeliness of disease reports, a key fundamental in effective public health response, is due in large part to the development of standards-based electronic reporting. This has reduced the burden on CDC's key reporting sources: healthcare providers and laboratories.
- Using the enterprise content management system, CDC launched ATACS (All Threats, Agents Content System) which serves as a specialized password protected repository of sensitive and non-sensitive information for emergency responders in CDC's bioterrorism preparedness program.
- CDC has successfully implemented an electronic workflow application based in the content management system designed to support the Agency's scientific clearance process.

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- CDC has successfully launched a public health partner portal aimed at delivering information and services to a broad range of CDC's partners. A critical service offered to public health partners during the flu vaccine shortage was the flu vaccine finder application which allowed local public health officials to track vaccine supplies and distribution in their area.
- CDC has successfully implemented a Public Health Directory system that consolidates information on people, organizations, and public health roles from multiple sources, serves as a central repository of this information for several new CDC systems, and implements the PHIN standards for electronic directories.
- CDC has contracted with the Federation of State Medical Boards to establish national directory data collection standards for State Medical Boards and protocols for sharing of data with public health agencies, in order to facilitate emergency alerting of private physicians in the event of a public health emergency.
- Developed a series of CDC UP Process Guides that guide project teams through processes required by regulatory mandates and PHIN and CDC standards (e.g., Information Security, Capital Planning, Privacy, Enterprise Architecture, and PHIN).
- The CDC Information Center won the Library Services A-76 competition. The new Library Services MEO achieves efficiencies by reorganizing library services across the agency into a single library system which emphasizes customer service.

**OUTPUT TABLE**

OUTPUT TABLE	FY 2006 ACTUAL	FY 2007 CR	FY 2008 BUDGET	FY 2008 +/- FY 2007
National Electronic Disease Surveillance System				
States actively engaged in ongoing NEDSS/PHIN-compatible systems integration	27	35	35	0
States developing NEDSS-compatible systems, in deployment, or live with the NEDSS Base System	40	50	50	0

**FUNCTIONAL TABLE**

PUBLIC HEALTH INFORMATICS (DOLLARS IN THOUSANDS)	FY 2006 ACTUAL	FY 2007 CR	FY 2008 BUDGET	FY 2008 +/- FY 2007
PHIN	\$4,829	\$4,833	\$4,418	(\$415)
NEDSS	\$24,751	\$24,751	\$24,751	\$0
Vaccine Registry	\$0	\$0	\$14,645	\$14,645
All Other Public Health Informatics	\$40,661	\$40,688	\$50,588	\$9,900
<b>Total</b>	<b>\$70,241</b>	<b>\$70,272</b>	<b>\$94,402</b>	<b>\$24,130</b>

## **HEALTH MARKETING**

### **AUTHORIZING LEGISLATION**

§§ 301, 304, 306<sup>1</sup>, 308, 307, 310, 311, 317<sup>3</sup>, 318<sup>1</sup>, 319, 319A<sup>4</sup>, 319B<sup>1</sup>, 319C<sup>4</sup>, 327, 352, 391<sup>3</sup>, 1102, 2315, 2341, Title XVII: 1702(a)2, 1702(a)3, 1702(4)(A), 1702(4)(C), 1703(a)(1), 1703(a)(2), 1703(a)(3), 1703(a)(4), 1703(c), 1704(1), 1704(2), 1704(3), 1704(6), Clinical Laboratory Improvement Amendments of 1988, § 4

<b>HEALTH MARKETING (DOLLARS IN THOUSANDS)</b>	<b>FY 2006 ACTUAL</b>	<b>FY 2007 CR</b>	<b>FY 2008 BUDGET</b>	<b>FY 2008 +/- FY 2007</b>
BA	\$39,180	\$39,210	\$38,710	(\$500)
PHS Evaluation Transfers	\$463	\$463	\$463	\$0
<b>Total</b>	<b>\$39,643</b>	<b>\$39,673</b>	<b>\$39,173</b>	<b>(\$500)</b>

### **STATEMENT OF THE BUDGET**

The FY 2008 Budget of \$39,173,000 for Health Marketing reflects a decrease of \$500,000 below the 2007 Continuing Resolution of \$39,673,000.

### **PROGRAM DESCRIPTION**

CDC's Health Marketing activities reflect CDC's commitment to directly engage and serve the people whose health we work to improve and protect. Health Marketing involves creating, communicating, and delivering health information and interventions using customer-centered and science-based strategies to protect and promote the health of diverse populations. Health Marketing uses commercial, non-profit, and public service marketing and communication science practices to better understand people's health-related needs and preferences; to motivate changes in individuals and organizations to protect and improve health; and to develop and enhance CDC's partnerships with public and private organizations to more effectively accomplish CDC's health protection goals.

As applied at CDC, Health Marketing serves a variety of functions:

- 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.
- Creative function: developing and delivering health messages and programs which get people's attention and resonate emotionally to position health as a means of achieving what people really value, such as having energy, staying independent, performing satisfying work and fulfilling emotional and spiritual needs.
- Program management function: strategically coordinating and leveraging all science-based communication and marketing activities within CDC to maximize its health impact and reduce the gap between research and practice.

In carrying out these functions, CDC accesses, promotes, and conducts research and analysis on customers, partners, and health intervention approaches; develops and evaluates strategies and methods for providing information, programs, and services; develops and tests communication messages and service-delivery programs for public and professional audiences; develops and coordinates high-priority partnerships and strategic alliances; 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 the best available public health science is rapidly and reliably translated into effective practice and policy.
- Ensure efficient use of CDC's resources, expertise and mechanisms for delivering health information and services.

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- Ensure that customers will have effective, real-time access to needed health and safety information, interventions, and programs through communication channels they prefer.
- Assure CDC content disseminated through various channels to the public and other targeted audiences is coordinated throughout the agency and is accurate, consistent, accessible, actionable, and evaluated for usability and customer satisfaction.
- Assure CDC's ability to communicate on terrorism and non-terrorism health events with timely, accurate and effective information to the public and targeted audiences.
- Ensure CDC, states, and other clinical and public health partners have a secure network to rapidly share, discuss, and analyze emerging information about potential threats and outbreaks.
- Ensure effective strategic partnerships and alliances to extend CDC's reach for effective health protection.
- Increase public awareness and partner actions to enhance the public health infrastructure.
- Help people understand what public health is as well as its relevance and value to people across all life stages.
- Promote and facilitate communication to measure progress toward agency goals and evaluate the impact of agency programs.
- Provide the technical capacity for CDC's research, science and programmatic information to be delivered electronically via the web.
- Ensure CDC's web content is delivered in an effective and accessible manner.
- Provide additional channels for electronic dissemination of CDC content, including innovative uses of new media.
- Improve CDC's ability to communicate in 'real time' using electronic methods of information dissemination.
- Help public health practitioners integrate principles from traditional marketing with public health research, theory, and practice.

Achieving CDC's health impact goals requires vigorous and active partnerships among federal, state and local health agencies as well as organizations representing those agencies. Through sector management, Health Marketing is providing a distinct focus on our public health partners, identifying their priorities and developing strategies for efficient working relationships.

Many activities essential to disease prevention and health promotion occur outside the traditional public health sector, such as in businesses, health care organizations, educational institutions, other federal agencies, and faith-based and community organizations. CDC has developed a systematic agency-wide approach to engage these organizations in CDC's health impact goals. With a special focus on private and public partnerships, CDC's Health Marketing activities provide staff and resources that enable the agency to engage these sectors more rapidly and effectively in health promotion and disease prevention.

These activities provide leadership in the development of CDC principles, strategies, and practices for effective communication to the public and other key CDC audiences for health promotion and disease prevention. It also functions as a CDC-wide forum for development and adoption of emergency and "long-lead" (e.g., feature magazine articles and television drama storylines) health communication policies and procedures. Additionally, it increases access to science-based health messages to increase impacts on the health of our customers.

CDC's Health Marketing activities also support the development of high quality educational products to effectively deliver messages to professional and public audiences about crosscutting, emergency, and public health programs. This support includes providing leadership and oversight to CDC's website, <http://www.cdc.gov> (CDC.gov), in designing and producing visual materials; managing the inventory, archiving and distribution of selected photo and other graphic images through the Public Health Image Library (PHIL); planning, producing, broadcasting, and archiving instructional television products; providing both scientific and general photographic services; and supporting translation of agency materials to multiple languages. Outreach via the Web is designed to maximize CDC's ability to disseminate and communicate information, as well as reach special audiences through the CDC en Español Web site for Spanish-speaking audiences, <http://www.cdc.gov/spanish/>. While use of television broadcast technology is being planned to reach public and professional audiences through an HHS-sponsored satellite TV network, other technologies such as podcasts and Really Simple Syndication (RSS) feeds are also being used to reach these audiences. The Public Health Training Network (PHTN) was developed over the past decade as a distance learning network to provide access to training for public health workers in all disciplines.

CDC's Health Marketing activities are also a locus for delivery of creative services that support health marketing activities. Specifically, this includes the development of graphic treatments for print, television and web-based communication, as well as writing and editing services that serve to help communicate scientific findings into clearly presented reports, articles, and multi-media programs. These services, provided agency-wide, help to ensure continuity and consistency across health topics and serve to ensure appropriate linkages to CDC's mission and goals.

CDC's main channel to communicate public health news about disease outbreaks and trends in health and health behavior is a family of publications that includes the *Morbidity and Mortality Weekly Report (MMWR) Weekly*, *MMWR Recommendations and Reports*, *MMWR Surveillance Summaries*, *MMWR Supplements*, and the *MMWR Summary of Notifiable Diseases*. These reports are the principal mechanisms for communicating public health information to state and local health agencies, health care providers and other health-related groups. All *MMWR* publications are currently published in hard copy and online. Special issues can also be published exclusively online as *MMWR Dispatches* or *Early Releases* at any time during episodes of critical public health need.

CDC's most prominent vehicle for gathering and communicating evidence-based information on the best available public health science to inform policymaking, practice and research is the *Guide to Community Preventive Services (Community Guide)*. The *Community Guide* is a family of printed and internet products that accurately encapsulate the available scientific evidence about what works to promote health and prevent disease in states, communities, local organizations, healthcare organizations, worksites, and schools. It provides one-stop shopping for scientifically-based recommendations about the use of effective public health programs and policies. The *Community Guide* is produced in close collaboration with an independent, non-federal Task Force on Community Preventive Services and numerous other scientific and public health partners. It evaluates and communicates state of the art knowledge about the effectiveness, economic efficiency, and feasibility of interventions to promote community health and prevent disease.

The overall mission of the CDC's Health Marketing activities is to protect and promote health and advance CDC's goals through innovative health marketing programs, products, and services that are customer-centered, high-impact, and science-based.

### **RATIONALE FOR THE BUDGET**

The FY 2008 Budget of \$39,173,000 for Health Marketing reflects a decrease of \$500,000 below the 2007 Continuing Resolution of \$39,673,000.

#### **Health Marketing Internal Support (-\$0.5 million)**

With a decrease of \$0.5 million in FY 2008, CDC will reduce support for embedded staff in the National Centers who perform marketing and communications functions; public health system funding to core partners; and consulting services for broadcast engineering. These reductions will be made through expected efficiencies as the functions of CDC's health marketing program continue to be enhanced.

### **PERFORMANCE ANALYSIS**

#### **Current Activities**

- Developing systematic reviews and evidence-based recommendations in the Community Guide that identify interventions and policies that will effectively attain critical public health objectives (e.g., CDC goals).
- Working with many CDC and other partners to enhance awareness, use, and impact of Community Guide findings on public health practice and research.
- Assessing lessons learned based on the recent e-coli outbreaks and subsequent activation. The Emergency Communications Branch (ECB) has been activated twice (August 2006 and December 2006) for food borne outbreaks. ECB is also engaged in pandemic influenza planning via 1) risk communication projects (media monitoring, evaluation and partnerships) as well as 2) preparing for full participation in three upcoming functional exercises, the first of which is January 31, 2007.
- Developing a comprehensive database of public and private partnerships to provide access to descriptive information on federal, state, local, tribal and private organizations that currently are funded or have collaborative partnerships with CDC. This repository of information enables CDC to strategically connect all activities within CDC and is an important vehicle to examine programmatic linkages and develop key strategies to meet health goals. In FY 2007, CDC will complete the first stage of the database by collecting information for a partnership list of contacts with vital information that can be used for event planning and can be securely accessed and edited online by CDC managers.

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- Building and engaging a network of influential organizations across sectors of society to work with CDC on health promotion and emergency preparedness. The network consists of key organizations representing business, educational, healthcare, faith-based and community organizations, and other federal agencies. Work with these organizations includes assessing the needs of their sectors for health information and services, and then producing and delivering those services. Within CDC a network of primary points of contact - called partner coordinators - for the external partners in each sector is being developed as well as a database providing detailed information about CDC's external partners.
- Partnership building activities are exemplified by recent activities for pandemic influenza preparedness. Working with influential partner organizations in the various sectors to assess the pandemic influenza preparedness needs of those sectors. Health Marketing responded to the most immediate needs by quickly developing pandemic influenza preparedness checklists to meet the needs of specific constituencies, such as businesses, local education agencies (K-12), colleges and universities, medical offices, home health care agencies, emergency medical services, child care organizations, and faith-based and community organizations. Currently, CDC is working to develop more detailed guidance for each of the sectors through the production of toolkits that will be available on-line.
- Hosting and maintaining the Web-based Public Health Training Network (PHTN) calendar of nationwide satellite and Web cast programs. The calendar is a well-known national clearinghouse for health-related distance learning programs including more than two dozen on terrorism-related topics such as anthrax, ricin, and smallpox, as well as epidemic threats such as SARS and West Nile virus. Plans are underway to expand the inventory of available learning resources to include products that will be instrumental for Pandemic Flu preparation and response.
- Providing web accessible, high-resolution Medical, Scientific and Historical Imagery free of charge with no restrictions on use through the Public Health Image Library (PHIL). PHIL images are routinely and increasingly used by a varied audience for bioterrorism agent identification, inclusion in public health-related publications, scientific text books, peer-reviewed journals, other websites, and television broadcasts. Increasingly, when CDC stories are reported in print or on the internet, PHIL imagery is used to provide a visual picture of the issue, helping audiences to understand and respond accordingly to public health threats or calls to action. With more than 6,000 unique visits each month, PHIL images are very high quality and authoritatively described. These attributes set it apart from any other photo library of its type.
- Providing safety and health-related information in dozens of languages other than English to improve compliance with Executive Order 13166, "Improving Access to Services for Persons with Limited English Proficiency." Spanish to English and English to Spanish translations are provided internally. A variety of other language translations are made available via the use of Blanket Purchase Agreements. Multilingual services at CDC assure that all translations distributed for public access are reviewed, edited as needed, certified as accurate and of the highest quality. Additionally, translations consistently follow terminology approved across the agency to help assure uniformity of product quality and writing style.
- As existing hotline contracts are expiring, CDC is transitioning them to the CDCINFO existing seven year contract. Currently CDC is consolidating clearinghouses and more than 40 hotlines that exist across the agency, including phone lines, emails, faxes, and mail. After consolidation, CDC verifies the success of the merger, trains staff on the new system structure, and establishes a liaison with the subject matter experts to resolve any issues that arise during the transition phase.
- Receiving, on average, 13 to 15 million hits per month on the MMWR Web site <http://www.cdc.gov/mmwr>. During times when there are urgent public health concerns, such as during the height of SARS outbreak and the outbreak of monkeypox in early 2003, the number of hits increases dramatically.
- Distributing CDC publications and/ or summaries, such as: the MMWR, Emerging Infectious Disease Journal (EID) and Preventing Chronic Disease through electronic channels (e.g. podcasts, RSS and Extensible Markup Language (XML) feeds).
- Developing a prototype market research and audience analysis database. This database will provide interactive access to information on key CDC audiences, including psychographic, demographic, consumer, behavioral and trend data.
- Providing ongoing consultation to CDC programs and external public health partners on how to systematically conceptualize, plan, execute, and evaluate health marketing and communication activities and campaigns. For example, working with the National Center for Infectious Diseases on a national Chronic Fatigue Syndrome awareness campaign; collaborating with the Department of Health and Human Services, Office of Women's Health, the National Bone Health Campaign for a 3-site community-based level health marketing intervention to increase girls' calcium consumption and weight-bearing physical activity;

consulting with CDC's National Center for Infectious Diseases on powdered infant formula and bacterial contamination; and consulting with the National Vaccine Program Office on the development of an evaluation plan for a vaccine education toolkit targeting clinicians and parents.

- Developing and testing performance support tools that can be used to improve the development, execution and evaluation of health marketing and communication interventions, e.g., performance support tools for program concept, planning and evaluation.
- Providing leadership and coordination for CDC's web presence to ensure CDC can effectively utilize the web to communicate information to multiple audiences. Providing CDC with ways to measure and analyze effectiveness of web efforts and providing ways to continuously improve CDC's web presence and audience access to CDC materials.
- Conducting large-scale usability testing on the CDC.gov website. Using usability testing data to create an improved site where users will be able to find the information they are looking for in a faster and more efficient manner.
- Providing expertise to CDC programs and campaigns regarding effective ways to integrate new media components into their activities.
- Working with CDC partners to integrate internal e-health activities with external technological advances in order to provide information to larger, more diverse audiences. Providing innovative solutions to meet the changing needs of public health communication activities.
- Facilitating seminars and trainings to improve web-based skills at CDC.

#### Significant Accomplishments

- Continued to support the development of a National Center for Public Health and Faith Collaborations at Emory University's Rollins School of Public Health as part of the White House's Faith-Based and Community Initiative. The overall purpose of the new center is to serve as a global hub for strengthening the partnership among CDC, Faith-Based Organizations, State and local governments, and other key national and international organizations so that they can align their unique assets to build capacity and advance knowledge to promote and protect the public's health.
- Developed a "CDC and External Organizations Networking Directory" as a means of connecting CDC and its external partners in a more rapid and efficient fashion. This directory will form the basis of a system for rapid communication in emergencies.
- Successfully convened CDC partners in Atlanta in March 2006 for the "Leaders to Leaders Conference: Engaging the Power of Partnerships." Approximately 300 partners and CDC leaders met to learn how CDC and its partners could collaborate more effectively for the nation's health. Another partners meeting is currently being planned for 2007.
- A Partnership Tool Kit was completed in August 2006 for CDC staff to serve as a resource in creating effective partnerships. This is now available on the Intranet.
- Published CDCSynergy (an evidenced-based communication planning guide) in 13 customized versions (e.g., Basic Edition, Emergency Risk Communication, Social Marketing, violence prevention, diabetes prevention and special editions for tobacco prevention, micronutrients, cardiovascular health, immunizations, diabetes, STD prevention), with three editions in production (malaria, environmental health, and 5-A-Day among American Indians/Alaska Natives). Developed the second version of Social Marketing CDCSynergy, a performance support tool for planning and integrating health marketing and communication within a larger public health program.
- Ensured that CDC information related to key health crisis situations in 2006 – most notably, Hurricanes Katrina and Rita – was accurate, internally consistent, timely, and coordinated with the Emergency Communication System. Additionally, preparation activities were conducted for avian influenza and a pandemic influenza outbreak.
- In conjunction with the Office of the Assistant Secretary for Public Affairs of the U.S. Department of Health and Human Services (HHS), CDC's ECB has developed pre-event messages (television, radio and print) and other resources for federal, state, local, and tribal public health officials to use during a response to an intentional event. The resources are available on the "First Hours: Initial communication with public during a potential terrorism event" web site, <http://www.bt.cdc.gov/firsthours/>.

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- Established a partnership with the Society for Public Health Education to increase emergency communication and collaboration between the Emergency Communication System (ECS) and state and local health educators in preparing for and responding to emergency events, including natural disasters, pandemic influenza, bioterrorism, and other emergency incidents that affect community health and environment. Establishing a two-way communication network with state and local health educators will help in identifying and responding to community-level education needs and special populations in affected areas.
- Developed and disseminated through SNAPSHOTs (SNAPS). The Snaps CD ROM database provides local level community profile information nation-wide. It can be browsed by county and state and searched by zip code. SNAPS serves as a valuable tool when responding to public health emergency events at the state and local levels. It provides a "snapshot" of key variables for consideration in guiding health education and communication efforts to ensure diverse audiences receive critical public health messages that are accessible, understandable, and timely.
- Epi-X posted 1,461 reports of outbreaks, Epi-Aids, and notification tests including reports on avian and pandemic influenza, anthrax, plague, imported mumps and measles, and Legionnaire's disease in the United States. Epi-X staff successfully evaluated the terrorism and non-terrorism emergency preparedness aspects of Epi-X through participation in announced and unannounced notification testing in all 50 states and three major metropolitan areas, as well as with EIS Officers. This included participation in two Director's Emergency Operations Center simulations and a system wide test of all 4,200 users.
- Produced 56 interactive satellite-based instructional programs, 44 videos, and 52 instructional multimedia programs reaching more than 250,000 public and private health workers at state and local levels since 2003 through the PHTN. These competency-based programs carry professional accreditation for clinicians, nurses, health educators, and other professionals.
- Implemented an agency-wide consolidation of graphics services at 38 percent below FY 2005 staff levels, delivering comprehensive graphic design, consultation and production and handling over 8,000 service requests from November 2005 to December 2006.
- Distribute the MMWR in paper and electronic format to more than two million persons annually.
- Published 19 issues of MMWR Recommendations and Reports, 12 issues of MMWR Surveillance Summaries, and two supplements in FY 2006. In addition, MMWR has continued to publish weekly reports, MMWR Supplements, MMWR Dispatches, and Early Releases. Beginning in October 2006, MMWR produced a weekly podcast of material extracted from that week's publication in the MMWR series.
- Provided actionable and science-based resources through the Community Guide that are the foundation for informing public health action by a range of public and private sector audiences. The Guide's reviews and recommendations have been used by many individuals and groups to support public health decision making (e.g., <http://www.publichealthgrandrounds.unc.edu/tobacco/index.htm>), to contribute to public health education (e.g., Am J Prev Med 2004; 27(5):417–422), and to contribute to improving the public health research base over time (e.g., <http://www.cpcrn.org/default.asp>). A Guide recommendation for sobriety checkpoints formed the basis for an intensive grassroots effort by Mothers Against Drunk Driving (MADD) to implement sobriety checkpoints across the country. In recognition of this contribution to their efforts, MADD awarded the Community Guide team the Ralph W. Hingson Research in Practice Award. The Community Guide has also contributed to saving lives. For example, one Community Guide recommendation (about laws requiring lower blood alcohol levels for drivers) contributed to Congressional incentives to states to pass these laws, resulting in new laws in 33 states and approximately 500 lives saved per year.
- Developed and executed a message testing and communication surveillance system in Nigeria for the purposes of providing communication and social mobilization experts with information required to effectively reach and influence target populations with messages related to an Avian Influenza outbreak.
- Consolidated communication staff from 15 CDC offices to improve the quality, consistency and timeliness of CDC communications.
- Launched the Health Literacy Liaison Certificate Program to train health educators and health communication specialists to provide expertise on health literacy, cultural competency, and translation awareness to their divisions on an ongoing basis. Currently, thirty-eight participants are enrolled in the program. Participants who complete the intensive, year-long training and pass performance-based assignments will be designated as health literacy liaisons.
- Completed baseline usability testing, including in-lab tests; internal surveys; external surveys; and a comprehensive review of data from the past two years of the American Customer Satisfaction Index reporting.

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- Implemented new techniques for maintaining the CDC website and its more than 250,000 pages, which included: creating a cross-cutting web governance structure to build an organized yet collaborative system for improving CDC's website; creating a content inventory tool to track web content owners and review dates for data; implementing a system where users can be notified when webpages are updated; and outlining a three-year plan for the adoption of a content management system.
- Coordinated new media activities for CDC's 2006 seasonal flu campaign, including: working with partners to post a graphic image on more than 80 federal and non-governmental web pages to promote this year's National Influenza Vaccination Week; hosting a webinar for blog writers; virtually vaccinating more than 10,000 teens against influenza via the education-based virtual environment Whyville; creating e-cards for distribution by the general public to serve as reminders for flu vaccinations; and creating an electronic media tracking system to monitor trends in online conversations related to influenza.

**OUTPUT TABLE**

OUTPUT TABLE	FY 2006 ACTUAL	FY 2007 CR	FY 2008 BUDGET	FY 2008 +/- FY 2007
Number of MMWR Publications	85	90	90	0
Number of Published Community Guide Findings annually	30	32	32	0
<b>Public Health Communications</b>				
Number of monthly visits to CDC Web site	13 million	15 million	15 million	0
Customer satisfaction with CDC Web site	75%	76%	76%	0
Number of monthly calls to 800-CDC-INFO	50,800	93,600	93,600	0
Customer satisfaction with 800-CDC-INFO	68%	72%	72%	0
Public health workers trained in CDCynergy	175	425	425	0
Programs produced for broadcast on PHTN and/or CDC-TV	27	30	30	0
CDC-wide priority campaigns coordinated through Executive Communications Council	3	5	5	0
Reports of outbreaks reported by Epi-X	1,475	1,500	1,500	0
<b>Public Health, Public, and Private Partnerships</b>				
Organizations included in CDC and External Organizations Networking Directory	100	250	250	0
CDC users of partnership coordination database	38	39	39	0

NARRATIVE BY ACTIVITY  
ENVIRONMENTAL HEALTH AND INJURY PREVENTION

**ENVIRONMENTAL HEALTH AND INJURY PREVENTION**

ENVIRONMENTAL HEALTH AND INJURY PREVENTION (DOLLARS IN THOUSANDS)	FY 2006 ACTUAL	FY 2007 CR	FY 2008 BUDGET	FY 2008 +/- FY 2007
BA	\$287,474	\$287,674	\$287,674	\$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. It assures that the establishment of priorities and the use of resources related to Environmental Health and Injury Prevention goals are aligned with CDC and HHS 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.

Dedicated scientific, communications, and program staff manage outstanding public health programs in areas such as asthma control, lead poisoning prevention, refugee health, child passenger safety, and violence prevention. In addition, CDC has the world's only Environmental Health Laboratory where scientists have developed advanced procedures for measuring chemicals in people's urine and blood, a process known as biomonitoring.

Many of the public health successes that were achieved in the 20th Century can be traced to innovations in environmental health practices. However, emerging pathogens and environmental toxins continue to pose risks and significant challenges to public health. The task of protecting people's health from hazards in their environment requires a broad set of tools. Principal among these tools is surveillance and data collection to determine which substances in the environment are affecting people and to what degree. The determination must be made as to whether these substances are harmful to humans and at what level of exposure.

Each day, 1,301 children suffer traumatic brain injuries, 1,294 teens attempt suicide and require medical attention to prevent death, and 801 older adults sustain hip fractures, but they represent only a small portion of the people who will be injured each year in the United States. CDC is a 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, 361, 1102, Housing and Community Development Act, 1021 (15 U.S.C. 2685), Title 50 – sections 1512 and 1521 of the Chemical Weapons Elimination Activities, Housing and Community Development (Lead Abatement) Act of 1992 (42 U.S.C. § 4851 et seq.)

ENVIRONMENTAL HEALTH (DOLLARS IN THOUSANDS)	FY 2006 ACTUAL	FY 2007 CR	FY 2008 BUDGET	FY 2008 +/- FY 2007
BA	\$149,161	\$149,264	\$149,264	\$0

### STATEMENT OF THE BUDGET

The FY 2008 Budget of \$149,264,000 for Environmental Health reflects level funding with the FY 2007 Continuing Resolution.

### PROGRAM DESCRIPTION

CDC's Environmental Health program was established in 1980 to focus on preventing disability, disease, and death caused by environmental factors. Today, CDC uses a combination of science, service, and partnerships to protect human health from environmental hazards by investigating the effects of the environment on health through laboratory and field research; tracking and evaluating environment-related health problems through surveillance systems; developing and implementing interventions and preventative actions; and assisting domestic and international agencies and organizations to prepare for and respond to environmental emergencies. In FY 2005, CDC consolidated its Offices of the Director for the National Center for Environmental Health (NCEH) and the Agency for Toxic Substances and Disease Registry (ATSDR). The two public health programs now share a management team and support staff.

CDC's Environmental Health program achieves its overall mission via multiple systems and interventions:

- Through its Environmental Hazards and Health Effects Program, CDC investigates the human health effects of hazards in the environment, such as water and air pollutants, mold, and radiation as well as hazards related to natural and other disasters. The results of these investigations help CDC develop, implement, and evaluate actions and strategies for preventing or reducing harmful exposures and their health consequences.
- Biomonitoring is the standard for assessing the exposure of people to toxic substances. It consists of measuring the levels of environmental chemicals in people's blood, urine, or other biological samples. For more than three decades, CDC laboratory scientists have investigated to which environmental chemicals people have been exposed, how much of these chemicals enter their bodies and stay long enough to be detected, and at what levels the chemicals in their bodies are related to health effects.
- CDC's National Environmental Public Health Tracking Program, established in FY 2002, provides federal, state, and local agencies with data to help them develop and evaluate effective public health actions related to preventing or mitigating health effects from exposure to environmental hazards. The data will also help health care providers offer more targeted and preventive services. In addition, the data facilitate better public understanding of health trends and events in their communities.
- CDC's National Asthma Control Program (NACP) was developed to build capacity in states to reduce the burden of asthma. Although the cause of and cure for asthma remain unknown, much is known about how to control the condition. CDC supports asthma data tracking, interventions, and partnerships nationwide. The NACP aims to reduce the number of asthma-related deaths, hospitalizations, emergency department visits, school and workdays missed, and limitations on activity.
- 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 U.S. between the years of 1976 – 1980, when an analysis of blood lead levels (BLLs) in children from the *National Health and Nutrition Examination Survey II* revealed that 88 percent of children from one to five years of age had elevated BLLs (10 micrograms per deciliter 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.

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- 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 public health. CDC's goal is to continue to prevent potential exposures to, and reduce negative health effects from, nerve and blister agents among workers and surrounding communities.
- CDC's Environmental Public Health Services Branch strives to strengthen the ability of local, state, and national environmental public health programs and professionals to anticipate, identify, and respond to hazardous environmental exposures and their health consequences. These services, necessary at all levels, are most often carried out at the local level (e.g., food safety, vector control, water and sanitation, indoor air quality, etc.) and are provided by front-line environmental public health professionals.
- The International Emergency and Refugee Health Branch uses public health and epidemiology to reduce the impact of complex humanitarian emergencies on the health of civilian populations.

CDC's environmental health efforts support the Secretary's 500-Day Plan in the area of research, where interdisciplinary and interagency collaboration in scientific pursuits is the standard, and broad scientific advances measurably reduce the burden of all chronic diseases. These efforts address all four CDC Health Protection goals: People Prepared for Emerging Health Threats, Healthy People in Every Stage of Life, Healthy People in a Healthy World, and Healthy People in Healthy Places.

### **RATIONALE FOR THE BUDGET**

The FY 2008 Budget of \$149,264,000 for Environmental Health reflects level funding with the FY 2007 Continuing Resolution.

### **PERFORMANCE ANALYSIS**

#### PART Results

As a result of its 2005 PART review, NCEH and ATSDR launched an external review program to evaluate all ongoing activities within the two agencies. A series of program evaluations will be completed by the agency's Board of Scientific Counselors, an external advisory board composed of subject matter experts. These evaluations will determine the effectiveness of each program, as well as its ability to meet targets and produce outputs. Two program reviews have been completed to date, with approximately three reviews completed each year. All NCEH projects are scheduled for review within the next five years.

In order to ensure compliance and completion of long-term program goals, NCEH listed all relevant goals and the process for achieving them in all new requests for application for the 2006 fiscal year. NCEH has also developed new performance measures to evaluate the capacity of state and other partners to achieve set targets and goals. The program will continue to develop an appropriate metric to measure state partner performance. The program is also continuing to develop performance tracking and measurement systems in accordance with CDC's budgeting and performance software database. NCEH also tracks performance and budget information in NCEH/ATSDR's internal project and performance databases, Project Profile and Compass.

#### Current Activities

- CDC assesses people's exposure to environmental chemicals as part of meeting its goal to determine human health effects associated with such exposures. Examples of this work include the following:
  - Evaluated exposure of the U.S. population to 274 environmental chemicals and nutritional indicators.
  - Developing a national report on indicators of nutritional status in the U.S. population. This first report will contain data on 27 indicators, including water- and fat-soluble vitamins, iron-status, phytoestrogens, and some trace elements.
  - Developing new methods for measuring human exposures to help meet its goal of determining the human health effects of environmental exposures.
  - CDC launched the Newborn Screening Translational Research Initiative, which is aimed at developing new screening methods for specific diseases affecting newborns. This initiative, along with CDC's continuing efforts to ensure quality standards in 987 laboratories throughout the country and abroad, helps meet the goal of determining human health effects associated with environmental exposures. CDC certifies quality standards for tests such as newborn screening; blood lead, cadmium, and mercury; those predictive of type 1 diabetes; and nutritional factors.

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- CDC continues to meet its goal of determining the human health effects associated with environmental exposures by conducting or collaborating on a variety of scientific studies. Examples include the following:
  - Funding and working with state, local and other federal public and environmental health agencies, universities, research organizations, national organizations, and others to identify, investigate, and track environmental hazards; measure exposure of people to these hazards; and prevent related health effects. Hazards include radiation, chemicals, air pollutants (e.g., carbon monoxide and mold), and water contaminants (e.g., algal toxins and chemicals).
  - Providing leadership and/or technical assistance for studies to identify and characterize environmental causes of observed health effects and to investigate and intervene to stop harmful exposures related to chemical, radiation, and natural disaster events.
  - Teaming with academic institutions, state health departments, and other partners on epidemiologic investigations. For example, CDC analyzed human samples in an investigation of mercury exposure among children in a day care center in New Jersey, which was the site of a former thermometer factory. In another investigation, CDC identified diethylglycol as the chemical responsible for the deaths of at least 50 people in Panama. The chemical was found in a cough syrup that had been taken by those who became ill and died.
  - CDC is funding 16 state health departments, one local health department and four schools of public health to build a national environmental public health tracking network. This network will enhance environmental public health tracking workforce and infrastructure; disseminate information to guide public health policy and practice; advance environmental public health science and research; and foster collaboration among health and environmental programs.
- In 2006, CDC's Environmental Health Laboratory collaborated on 52 environmental health studies. This research is critical in helping to meet the goal of determining the human health effects associated with exposures to environmental chemicals. For example, CDC collaborated with University of Tennessee researchers to evaluate the effects of exposure to persistent pesticides on health and childhood development. CDC also collaborated with Columbia University to assess the exposure of African-American and Dominican children to organophosphate pesticides and documented reduced exposure to these pesticides among these children. In addition, CDC provided measurements for research studying genetic susceptibility, nutritional factors, and selected chronic diseases.
- CDC's National Asthma Control Program funded grantees in 33 states, the District of Columbia, Puerto Rico, and other partners—including other federal agencies, universities, and national organizations—to meet its goal of reducing the burden of asthma. Efforts to accomplish this goal include health education, research, intervention, tracking, and other programs. Sample projects include the following:
  - Supporting the collection of in-depth state and local asthma data through development and testing of a National Asthma Survey module. In 2005, eight states (Alabama, California, Illinois, Minnesota, Michigan, Oregon, New York, and Texas) were in various phases of implementing the module. In FY 2006, 25 states conducted the survey; 35 states plan to conduct the survey in FY 2007.
  - Supporting state efforts to evaluate their asthma control programs and activities by developing evaluation guidance and plans.
  - Partnering with national organizations (e.g., the American Lung Association, the Asthma and Allergy Foundation of America, and the Allergy and Asthma Network Mothers of Asthmatics) to conduct asthma education. These activities range from identifying effective educational programs for adults to educating children with asthma as well as their families and caregivers.
- CDC provides technical assistance, public health training, and evaluation of responses to large-scale public health emergencies. This work helps to meet the goal of preventing or reducing environment-related injuries and deaths. CDC's efforts include the following projects:
  - Contributing to CDC's response to several public health emergencies, including those resulting from the flight of refugees from the Darfur region of Sudan; the Indonesian tsunami; Hurricanes Katrina and Rita; drought and emergency conditions in the Horn of Africa; major earthquake in Pakistan; vaccination of children in south Sudan; and famine conditions in Niger.
  - Providing technical assistance to other federal agencies, the United Nations (U.N.), and nongovernmental organizations (NGOs) in order to protect the health of people affected by international complex humanitarian emergencies (CHEs); working with international partners to identify the number and nature of landmine-related injuries and deaths, providing technical assistance and training in public

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health emergency planning, and conducting training for constituents at CDC, educational institutions, and international organizations.

- Providing public health-related teaching and training on nutrition, water, and sanitation, and mine-action. This included a training course in Cambodia for UNICEF mine-action workers.
- Developing a distance-learning program to increase field-level capacity to respond to CHEs. These training courses will significantly increase the capacity of the U.N. and international NGOs to respond to emergencies and appropriately target donor aid.
- Conducting and evaluating the impact of health responses to CHEs. CDC is currently a key partner in a multinational effort to provide an evaluation framework for health interventions in CHEs. CDC continues to support missions in war-affected countries to refine methods that will help aid providers to better target their interventions.
- Supporting emergency preparedness and response activities for natural disaster as well as chemical and radiation events, including the training of public health, medical, and other responders; developing and disseminating scientific and educational tools and resources; and providing states and others with technical assistance following events to help improve responses.
- CDC funded 14 cooperative agreements in 11 states to help meet its goal of helping states and tribal governments to improve their environmental public health services. This funding went to state and local public health departments and to academic centers as part of CDC's effort to support its National Strategy to Revitalize Environmental Public Health Services. For example, CDC:
  - Provided technical assistance and information to a total of more than 3,800 state, local, and tribal environmental health programs throughout the U.S; and,
  - Responded to state requests for technical assistance in conducting environmental outbreak investigations, hazard evaluations, and community environmental assessments.
- CDC funds five schools of public health to meet its goal of training environmental public health services professionals. Activities include the following:
  - Training state and local health officials in developing effective environmental public health programs aimed at improving response to current and emerging public health threats. This training advances public health practice by expanding the science base in environmental public health.
  - Providing training on a variety of topics, including water quality, food safety, terrorism, vector management, healthy homes, systems-based problem-solving during hazard evaluations, and outbreak investigations.
- CDC has initiated research on the impact of the built environment on public health. Preliminary evidence suggests that the built environment may have a large effect on our health. For example, sidewalks connecting houses with schools and retail shopping centers may result in more walking, which results in more exercise and reduced incidence of diseases such as obesity, diabetes, and heart disease. In addition, CDC is working with partners to provide tools to assist local public health officials and community planners in making decisions that promote health when designing communities. The Health Impact Assessment (HIA) is one such tool that CDC is testing in community settings.

Significant Accomplishments

- Developed 16 new laboratory methods to measure human exposure to additional priority chemicals and nutritional indicators. Among these advances are methods for measuring polyunsaturated fatty acids in vitamin A in blood spots and serum; phthalates; and speciated metals, such as arsenic.
- Ensured that laboratory quality standards are maintained in certified or participating laboratories. In FY 2006, 987 laboratories participated in quality assurance or clinical laboratory certification programs.
- Supported completion of 30 environmental public health tracking assessments examining the possible association between a health effect and an environmental exposure and/or hazard. These data led to 21 public health actions. For example, the Massachusetts Tracking Program found a statistically significant association between the presence of moisture problems in a school and pediatric asthma prevalence, indicating a need for public health follow-up or intervention, and provided information for policy changes aimed at reducing mold and moisture in schools. The program is working with school officials to identify how to remediate the moisture problems. Such efforts are helping to establish the foundation for a National Environmental Public Health Tracking Network.

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- Continued work on emergency preparedness and response for natural disaster, chemical, and radiation emergencies. For example, CDC:
  - Identified carbon monoxide (CO) poisoning risk factors related to generator placement and improper CO detector use and provided recommendations for revising prevention messages;
  - Evaluated the American Red Cross (ARC) morbidity and mortality surveillance system after Hurricane Katrina and made recommendations to ensure better data capture and to improve flow of information to and from the field;
  - Trained 95 public health workers in conducting rapid needs assessments;
  - Worked with the American Association of Poison Control Centers to help local poison control centers detect chemical exposure events and ensure effective responses;
  - Developed and disseminated a number of education materials to help the public protect their health before, during, and after an event; and,
  - Developed standardized surveillance tools to collect information about morbidity and mortality in the post-disaster setting and made them available to public health professionals via the Internet.
- Completed 34 studies to determine the harmful health effects from environmental hazards and to recommend appropriate public health actions based on the study results. These studies focused on the health effects of air pollutants, water contaminants, chemicals, and radiation. For example, CDC helped identify and characterize environmental hazards related to certain inks in permanent (i.e., tattooed) eye makeup; mercury exposure of children in New York City; persistent pesticides in mothers and children; fentanyl-related deaths among illicit drug users in Michigan; ciguatera poisoning and surveillance in Florida and Puerto Rico; aflatoxicosis outbreak in Kenya; and shellfish poisoning in Nicaragua. In addition, CDC conducted a number of assessments related to the risk factors, hazards, and responses to Hurricanes Katrina, Rita, and Wilma.
- Built capacity to respond to asthma at the state and local levels in the following ways:
  - Funded state programs to develop evaluation plans to monitor the impact of intervention activities on the burden of asthma;
  - Created an inventory of interventions and surveillance activities undertaken by state asthma programs; and,
  - Supported 34 health departments in developing comprehensive asthma surveillance reports, and 25 states in collecting data through the Behavioral Risk Factor Surveillance System asthma survey.
- Made advancements in the elimination of childhood lead poisoning by providing technical assistance to states not receiving grants for addressing childhood lead poisoning. For example, the program's work with Mississippi resulted in the first ever submission of Mississippi blood lead surveillance data to CDC and allowed for CDC to help in developing the state's strategic plan for elimination of childhood lead poisoning.
- Reduced the percentage of children with blood lead levels above the 10 µg/dL threshold. This figure has declined from an estimated 4.4 percent 1991–1994 to 1.2 percent in 2003–2004.
- Conducted the first emergency nutrition and mortality survey of refugees from the Darfur region of Sudan. The survey found acute malnutrition at rates of up to 39 percent in refugee camps and border settlements. CDC found that, among children ages six months to five years in refugee camps and border settlements, 35–58 percent have diarrheal diseases, and measles vaccination is inadequate (ranging from 24–83 percent in the camps and settlements) to prevent outbreaks. This data has been used to guide U.S. government humanitarian activities in the region and to improve allocation of resources.
- Responded to the public health crisis caused by the December 2004 Indian Ocean earthquake and resulting tsunami. Conducted three health and nutrition surveys in Aceh Province, Indonesia. The surveys helped local officials to plan appropriate interventions for affected populations. CDC staff also conducted the first health facilities assessment in Indonesia following the disaster and provided mental health support to hundreds of relief workers, medical staff, and mortuary staff in Thailand.
- Assisted with the planning and implementation of a mass measles immunization campaign which targeted five million children aged six months to 15 years. Campaign implementation began in the southern equatorial regions and by March 2006 an estimated 500,000 children were vaccinated. A plan of action was drawn up for the entire region covering the period to the end of 2006. Technical support for surveys is ongoing.

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ENVIRONMENTAL HEALTH AND INJURY PREVENTION  
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- Responded to a Congressional request to analyze the Army's proposal for off-site treatment and disposal of caustic VX hydrolysate from the Newport, Indiana, Chemical Agent Stockpile Disposal Facility. The final analysis was completed in the summer of 2006.
- Provided public health oversight of the Army's successful campaign to start-up VX rocket disposal in Anniston, Alabama and bulk mustard chemical agent in Toole, Utah.
- Provided public health oversight of the Army's successful completion of the destruction of mustard chemical-agent and ensuing facility closure in Aberdeen, Maryland as well as final closure of the former VX production facility in Newport, Indiana.
- Provided public health guidance to the Army relating to offsite destruction of waste generated by the destruction of chemical agents from Aberdeen, Maryland and Anniston, Alabama.
- Worked on issues at all of the four incineration and two neutralization sites dedicated to disposing of chemical weapons. While several serious incidents occurred during the year, there were no deaths or serious injuries associated with chemical agents.
- Produced and distributed an updated Health Housing Reference Manual in cooperation with the Department of Housing and Urban Development. The new resource, a centerpiece to CDC's Healthy Homes Goal, is designed to be used by local health, environmental health, and housing departments to provide comprehensive recommendations to make homes healthier and safer. Some of the public health issues addressed by the manual include indoor air pollution, rodents and other disease vectors, waste water disposal, and lead poisoning prevention.
- Trained more than 700 public health and housing practitioners in techniques for ensuring that homes are safe and sanitary as a means for preventing disease and injury. This unique training of public health, environmental health, and housing inspection officials is a model for addressing cross-cutting public health challenges.
- Produced and distributed educational and training guides regarding on-site waste management; land use planning; all-hazards emergency response; control of insects and rodents; and community environmental health assessment.
- Graduated the first class of 30 students from CDC's Environmental Public Health Leadership Institute (EPHLI). This year-long program teaches a systems-based approach to addressing environmental public health challenges as well as cutting-edge leadership skills and techniques. An additional 40 students are taking part in the current EPHLI training session.
- Funded nine states related to CDC's Environmental Health Specialists Network (EHSNet), which helps to identify and prevent environmental factors contributing to food-borne and water-borne illness and disease outbreaks.

### OUTPUT TABLE

OUTPUT TABLE	FY 2006 ACTUAL	FY 2007 CR	FY 2008 BUDGET	FY 2008 +/- FY 2007
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 <sup>1</sup>	987	1,001	967	(34)
EHHE Health Tracking Data (number of states) <sup>2</sup>	10	0	0	0
Laboratory studies conducted to measure levels of environmental chemicals in exposed populations	50	50	50	0
Public health actions developed (using Environmental Health Tracking data) that prevent or control potential adverse health effects from environmental exposures	17	22	34	12
Funded state and local lead programs that develop and implement elimination plans <sup>3</sup>	43	43	41	(2)
State, local, and territorial programs funded to develop or implement comprehensive asthma control plans	34	34	34	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	8	8	8	0
Percentage of nations with unified and coordinated strategy for responding to international health emergencies	12	12	12	0
Percentage of chemical stockpiles that are disposed of without serious injuries or deaths from chemical agents	100	100	100	0

<sup>1</sup> The standardization programs are entirely voluntary, and the number of labs that participate fluctuates due to multiple factors, including CDC laboratory requirements and import restrictions.

<sup>2</sup> Project ends in FY 2006.

<sup>3</sup> A reduced number of states have applied for grants within the new funding cycle starting in FY 2008.

### FUNCTIONAL TABLE

ENVIRONMENTAL HEALTH (DOLLARS IN THOUSANDS)	FY 2006 ACTUAL	FY 2007 CR	FY 2008 BUDGET	FY 2008 +/- FY 2007
Environmental Health Laboratory	\$26,923	\$26,942	\$26,942	\$0
Environmental Health Activities	\$54,586	\$54,623	\$54,623	\$0
Asthma	\$31,828	\$31,850	\$31,850	\$0
Childhood Lead Poisoning	\$35,824	\$35,849	\$35,849	\$0
Total	\$149,161	\$149,264	\$149,264	\$0

NARRATIVE BY ACTIVITY  
ENVIRONMENTAL HEALTH AND INJURY PREVENTION  
INJURY PREVENTION AND CONTROL

## INJURY PREVENTION AND CONTROL

### AUTHORIZING LEGISLATION

PHSA §§ 301, 307, 310, 311, 317, 319, 327, 352, 391-394A, 1252, Use of Allotments for Rape Prevention Education (393B), Section 4, P.L. 104-166 (expired), Sec 413 of the Family Violence Prevention and Services Act of 2003

INJURY PREVENTION AND CONTROL (DOLLARS IN THOUSANDS)	FY 2006 ACTUAL	FY 2007 CR	FY 2008 BUDGET	FY 2008 +/- FY 2007
BA	\$138,313	\$138,410	\$138,410	\$0

### STATEMENT OF THE BUDGET

The FY 2008 Budget of \$138,410,000 for Injury Prevention and Control reflects level funding with the FY 2007 Continuing Resolution.

### PROGRAM DESCRIPTION

Injuries are the leading cause of death among children and adults under 44 years of age in the U.S. In 2004, more than 167,000 people died from injuries and violence, and over 29 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 cost associated with both fatal and nonfatal injuries that occurred in 2000 is estimated to exceed \$406 billion.

CDC works to prevent premature death and disability, and to reduce the human suffering and medical costs caused by injuries and violence. Like diseases, injuries are preventable—they do not occur at random. CDC's Injury Center uses the same scientific methods to prevent injuries that have been used to prevent disease: carefully describing the problem through data collection and monitoring, studying factors that increase or decrease risk for injury, designing and evaluating intervention strategies that target these risk factors, and taking steps to ensure that proven strategies are disseminated, replicated, and implemented in communities nationwide.

CDC has four priorities of focus to ensure optimal utilization of previous research and programmatic knowledge and to achieve a reduction in injuries and their consequences in the U.S. These priority areas address CDC's Health Protection Goals for Infants, Children, Adolescents, Older Adults, and Healthy Homes. The areas of focus are 1) the prevention of child maltreatment prevention, 2) older adult falls, 3) injuries from residential fires and 4) improving teen driving safety.

- Children who experience maltreatment are at increased risk for adverse health effects and behaviors as adults—including smoking, alcoholism, drug abuse, eating disorders, severe obesity, depression, suicide, sexual promiscuity, and certain chronic diseases. CDC has invested in research to identify effective strategies to prevent child maltreatment. CDC has identified health care professionals as important partners for preventing abusive head trauma in early infancy. CDC is reaching out to health care organizations in order to develop prevention collaborations for abusive head trauma and other forms of child maltreatment. In addition, CDC is supporting further examination of the role of safe, secure, nurturing relationships to enhance child growth and development and prevent child maltreatment.
- More than one third of adults ages 65 years and older fall each year. Of those individuals who fall, 20 percent to 30 percent suffer moderate to severe injuries such as hip fractures or head traumas that reduce mobility and independence, and increase the risk of premature death. CDC supports research to determine the factors that put people at risk, factors that protect them from harm, as well as the effectiveness of interventions to prevent falls and fall-related injuries among older adults. CDC is working with state and local agencies to disseminate the most effective falls prevention programs and to implement them in communities where they can have the greatest impact.
- On average in the U.S. in 2003, someone died in a fire about every two hours and someone was injured every 29 minutes. In 2004, fire departments responded to more than 410,000 home fires in the U.S. which claimed the lives of an estimated 3,190 people (not including fire fighters) and injured another 14,175. Almost half of home fire deaths occurred in homes without working smoke detectors. Residential fires accounted for approximately 80 percent of all fire-related injuries and deaths in 2004. CDC's residential fire death and injury prevention activities have a long history of moving from research to practice. CDC funded research activities that evaluated the effectiveness of smoke alarm installation programs determined them to be programmatically effective and cost effective. CDC is working with states and local communities to

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- introduce and incorporate the effective Smoke Alarm Installation and Fire-Safety Education Program into more communities to protect the safety of those most at risk for injuries and death from residential fires.
- Two out of five deaths among U.S. teens result from motor vehicle crashes. CDC is working to better understand how teens understand and process information on safety and health risks. This work will inform efforts to keep teens safe in motor vehicles, but will also enhance other prevention activities targeting adolescents. CDC is also particularly interested in better understanding how to work with parents to ensure that teen drivers develop safe driving habits under low-risk conditions and the role of parents in introducing more challenging driving situations as the novice driver gains experience.

CDC is uniquely positioned to prevent injuries and violence before they occur, protecting people across the life stages from harm and saving significant health care resources. CDC has the experience as well as the public and private partners necessary to research, develop, and communicate effective methods to prevent injuries and violence.

### **RATIONALE FOR THE BUDGET**

The FY 2008 Budget of \$138,410,000 for Injury Prevention and Control reflects level funding with the FY 2007 Continuing Resolution.

### **PERFORMANCE ANALYSIS**

#### PART Results

Following its PART review in FY 2006, the National Center for Injury Prevention and Control (NCIPC) is working to tie budget requests to annual and long-term goal accomplishments which will enable the Center to present complete and transparent resource needs. Improvements in monitoring and reporting programmatic progress in achieving goals and efficiency measures are also being developed and utilized by both the internal staff and extramural partners. Annual external scientific reviews are currently being scheduled to ensure that the program is effective and achieving results in accordance with the standards and needs of the at-large scientific community.

#### Current Activities

CDC supports injury surveillance and 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 assist with disseminating and implementing those programs that are proven to prevent disability and death.

- Preventing Child Abuse and Neglect:
  - Supporting, in collaboration with the Duke Foundation, three projects examining the effects of information and communication technology (e.g., cell phones, internet, video conferencing, web cameras) on cost-effectiveness and program outcomes to reduce child maltreatment when these technologies are added to a previously demonstrated efficacious or effective parenting program.
  - Home visiting programs have been reported to be effective; however, the relative effectiveness of home visiting at preventing child maltreatment varies. CDC funds two studies to determine the specific training practices that will improve staff performance and family outcomes in home visiting programs.
  - Focusing on adult and community responsibility to prevent the perpetration of child sexual abuse by funding three states (Georgia, Massachusetts, and Minnesota) to create collaboratives. The funding supports projects using existing infrastructures to broaden prevention efforts. The collaboratives complement existing programs that focus on victim identification and services in order to build a comprehensive approach to child sexual abuse.
  - Supporting three national organizations for the BECAUSE (Building and Enhancing Community Awareness United for Safety and Empowerment) Kids Count! Program to build or expand their capacity and the capacity of their state, local, and/or regional affiliates to address the prevention of child maltreatment, which includes physical abuse, emotional abuse, neglect, and sexual abuse.
  - Applying the public health approach to the prevention of violence perpetrated toward or among children and adolescents through CDC funding and support for the implementation of state plans in two state health departments. This project focuses on implementing 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.

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- Preventing Falls Among Older Adults: Supporting the translation of an evidence-based Tai Chi program into a user-friendly resource package for community-dwelling older adults to assess the feasibility of implementing key elements of the package through local senior service providers.
- Eliminating Residential Fire Deaths: CDC funds 17 states or communities to provide 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.
- Increasing Seat Belt Use Among Adolescents: CDC funds the implementation and evaluation of multi-component community-based interventions to increase seat belt use among adolescent drivers and their passengers. This work is also obtaining process-related information regarding barriers to implementation of such interventions and the means to overcome them. This information will be used to inform future community-based interventions to increase seat belt use among adolescents.
- State Injury Prevention and Control Programs: CDC funds 30 states to build basic injury prevention programs, including the planning, implementation and integration of comprehensive injury prevention and control activities with basic injury surveillance activities, including traumatic brain injury (TBI) surveillance. CDC also supports efforts in six states to gather more in-depth information about the incidence of TBI using state-wide hospital discharge and emergency department data, and/or to provide individuals who have sustained a TBI with information about available services in their state.
- Rape Prevention and Education: CDC addresses rape prevention by supporting every state, Washington, D.C., Puerto Rico, and seven territories through the Rape Prevention and Education grant program. CDC provides resources and assistance to states and territories for rape prevention and education programs conducted by rape crisis centers, state sexual assault coalitions, and other public and private nonprofit entities. CDC assists state and coalition staff through training opportunities, support for the National Sexual Violence Resource Center, and research to learn what works in preventing rape.
- Intimate Partner Violence Prevention Programs: The Domestic Violence Prevention Enhancement and Leadership through Alliances (DELTA) program is funded by CDC in 14 states. DELTA supports state domestic violence coalitions to provide prevention-focused technical assistance, training, and funding to local communities. CDC is also funding two projects for the prevention of sexual violence and intimate partner violence among racial and ethnic minority populations. The focus is on working with men and boys in culturally appropriate ways to prevent sexual violence and intimate partner violence before it occurs. In addition, intervention and evaluation trials are funded by CDC in four sites to test intervention strategies to prevent intimate partner violence and its negative consequences.
- National Violent Death Reporting System (NVDRS): CDC funds 17 states to implement the NVDRS and gather and share state-level data about violent deaths. State and local agencies already have detailed information from medical examiners, coroners, police, crime labs, and death certificates that could answer questions about trends and patterns of violence. However, the information is fragmented and difficult to access. NVDRS brings together this information to form a timelier and complete picture of the circumstances of the violent death. This information can be used to develop, inform, and evaluate violence prevention programs.
- National Electronic Injury Surveillance System: All Injury Program (NEISS-AIP): NEISS-AIP is a national probability sample of hospitals with emergency departments (EDs) in the United States. and its territories. NEISS-AIP data are utilized to calculate national estimates of all types and causes of nonfatal injuries treated in hospital EDs and are important for monitoring trends over time and for designing and evaluating national, state, and community-based injury prevention programs. NEISS-AIP is collaboration between the U.S. Consumer Product Safety Commission and CDC. Data collected by this system are available through WISQARSTM (Web-based Injury Statistics Query and Reporting System), an interactive database system that can be accessed at <http://www.cdc.gov/ncipc/wisqars>.

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. CDC's research identifies effective strategies to prevent injuries, strategies that must then be widely disseminated.

- Injury Control Research Centers: CDC's Injury research demonstrates what works to keep people safe through injury research. CDC funds 12 university-based Injury Control Research Centers throughout the U.S. to conduct research and provide state and community training and technical assistance. These research centers work to identify critical gaps in knowledge of injury risks and protection, particularly among

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vulnerable populations; conduct important research to address these gaps and disparities; and communicate their findings to community public health workers to shape effective programs.

- Centers of Excellence on Youth Violence: CDC funds eight 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. CDC also funds two Urban Partnership Academic Centers of Excellence (U-PACE) to address youth violence in targeted high-risk communities.
- Extramural Research Grants Program: CDC supports a highly successful investigator-initiated, peer-reviewed grant program for academic research institutions across the country. 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 provide an alert for motor vehicle occupants exposed to dangerous carbon monoxide levels.

Significant Accomplishments

- Preventing Residential Fire Deaths: A review of homes participating in CDC-funded smoke alarm installation and fire safety education programs found that approximately 1,164 lives have been saved to date. Program staff have canvassed over 402,000 homes and installed more than 295,000 long-lasting or lithium-battery powered smoke alarms in high-risk homes, specifically those with children ages five years and younger and adults ages 65 years and older. Through both the year-round promotion of the program in each community (via local radio, television, newspapers, church bulletins, health clinics, etc), and the education and smoke alarm installations that occur in each participant's home, fire safety activities and messages have reached individuals and populations in greatest need.
- Expanding Reach Through Partnerships: One in 11 adolescents reports being hit, slapped or physically hurt by a dating partner each year. This and other recent research led to the development of a new CDC initiative to help adolescents, ages 11 to 14 years old, form healthy relationships. The initiative entitled, "Choose Respect," seeks to prevent dating violence before it ever starts. Throughout the summer of 2006, CDC worked with community agencies in 10 cities to create awareness of the initiative's themes and resources among 11 to 14 year-olds and their parents. By garnering private partnerships with corporations such as the Women's National Basketball Association, Houston ASTROS, Verizon Wireless, AVON, Lifetime television, Ben and Jerry's Ice Cream, Liz Claiborne, the Community Health Network, the African Methodist Episcopal Church, and Union Bank, each community agency was able to maximize the impact and reach of the initiative efforts. These private partners helped community agencies market and leverage initiative resources by contributing in-kind media air-time, services and venues, and other direct funding. These efforts ensured that over 500,000 adolescents and parents heard the Choose Respect message in the summer of 2006 and will continue through FY 2007 and FY 2008.
- Evaluating the Impact of Trauma Care: A CDC-funded study at Johns Hopkins and the University of Washington examined the differences in mortality between Level 1 trauma centers and hospitals without a trauma center. The study found that care at a trauma center lowers the risk of death for injured patients by 25 percent compared to treatment received at non-trauma centers. This research is among the first to provide strong evidence of the effectiveness of specialized trauma-care facilities.
- Documenting the Cost of Injuries: CDC found that the lifetime cost of injuries occurring in a single year in the U.S. totals an estimated \$406 billion in medical expenses and productivity losses (including lost wages, fringe benefits, and ability to perform normal household responsibilities.) Nearly \$80.2 billion is attributed to medical expenses, while \$326 billion is estimated for lifetime productivity losses for the almost 50 million injuries that required medical treatment in 2000. Police services, caregiver time, costs for pain and suffering, and other non-monetary costs are not included in this analysis.
- Strengthening Military Physician Response to TBI: CDC is working with the Defense and Veterans Brain Injury Center (DVBIC) to disseminate the *Heads Up: Brain Injury in Your Practice* tool kit to military physicians to increase their awareness of traumatic brain injury (TBI). Over 2,500 tool kits were initially distributed to military and veterans hospitals around the globe. Additionally, *Heads Up: Brain Injury in Your Practice* has been used as a handout in TBI trainings at military bases including Bagdad in Iraq, Landstuhl in Germany, Fort Carson, Fort Dix and Fort Knox in the United States. The tool kits have also been distributed to physicians at major military meetings and conferences. Sharing this information with

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military physicians can assist them in quickly diagnosing and appropriately managing TBI among military personnel.

- Enhancing the Measurement of Intimate Partner Violence: CDC developed and disseminated the *Intimate Partner Violence Victimization and Perpetration: A Compendium of Assessment Tools*. This Compendium is a collection of instruments to measure victimization and perpetration of intimate partner violence (IPV), including physical violence, sexual violence, psychological abuse, and stalking. It is an important resource for professionals who are conducting research on IPV or who are planning or evaluating IPV prevention and intervention programs. The ability to accurately measure IPV is critical for the success of research and prevention activities.
- Preventing Older Adult Falls: CDC has released new educational materials to help older adults prevent falls. Through a partnership of the CDC Foundation and the MetLife Foundation, brochures and posters were updated, redesigned, and translated into Spanish and Chinese. Through the promotion and distribution of these materials — appropriate for use by older adults as well as by their friends, family members, and health care providers — CDC seeks to increase older adults' knowledge and understanding of ways to prevent falls. More than 25,000 copies of *What You Can Do to Prevent Falls*, 26,000 copies of *Check for Safety: A Home Fall Prevention Checklist for Older Adults*, and 1,000 sets of posters have been distributed to date. These materials are available for free at: [www.cdc.gov/ncipc/pub-res/toolkit/brochures.htm](http://www.cdc.gov/ncipc/pub-res/toolkit/brochures.htm).
- Improving Routine Trauma Care: CDC has worked with numerous partners to advance the field's understanding of the role of trauma care to reduce alcohol misuse. Admission to a trauma center or an emergency department provides a chance to identify patients who are drinking excessively or who have substance use problems. Intervention trials that used brief counseling sessions for those with alcohol and drug problems have reportedly reduced recidivism by up to 50 percent and have significantly decreased the number of binge drinking episodes and drinks consumed per week. In March 2006, the American College of Surgeons Committee on Trauma announced that as part of the certification process Level II trauma centers would be required to screen patients for alcohol problems as routine practice. In addition, Level I centers would be required to provide an evidence-based intervention for screen-positive patients. The chair of the committee acknowledged the important role played by a CDC-organized conference on this topic and by the conference proceedings published as a special supplement of the *Journal of Trauma*.

**OUTPUT TABLE**

OUTPUT TABLE	FY 2006 ACTUAL	FY 2007 CR	FY 2008 BUDGET	FY 2008 +/- FY 2007
Injury Prevention and Control Surveillance and Programs				
Child Maltreatment Prevention Activities	13	13	13	0
Older Adult Fall Prevention Activities	1	1	1	0
Residential Fire-Related Injury Prevention Programs	17	17	17	0
Teen Driving Safety	1	1	1	0
Core State Injury Prevention and Control Programs	30	30	30	0
Rape Prevention and Education Grants	59	59	59	0

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OUTPUT TABLE	FY 2006 ACTUAL	FY 2007 CR	FY 2008 BUDGET	FY 2008 +/- FY 2007
Intimate Partner Violence Prevention Programs	20	20	20	0
National Violent Death Reporting System	17	17	17	0
National Electronic Injury Surveillance System – All Injury Program (NEISS-AIP)	1	1	1	0
<b>Injury-Related Research</b>				
Injury Control Research Centers	12	12	12	0
Centers of Excellence in Youth Violence	10	10	10	0
Research Grants to Individual Investigators for Injury Prevention	52	52	52	0

**FUNCTIONAL TABLE**

INJURY PREVENTION AND CONTROL (DOLLARS IN THOUSANDS)	FY 2006 ACTUAL	FY 2007 CR	FY 2008 BUDGET	FY 2008 +/- FY 2007
Intentional Injury	\$103,492	\$103,565	\$103,565	\$0
Unintentional Injury	\$34,821	\$34,845	\$34,845	\$0
<b>Total</b>	<b>\$138,313</b>	<b>\$138,410</b>	<b>\$138,410</b>	<b>\$0</b>

## OCCUPATIONAL SAFETY AND HEALTH

### AUTHORIZING LEGISLATION

PHSA §§ 301, 304, 306, 307, 310, 311, 317, 317A, 317B, 327, Occupational Safety and Health Act of 1970 (P.L. 91-596), §§ 9, 20-22 (29 USC 657), Federal Mine Safety and Health Act of 1977, P.L. 91-173 as amended by P.L. 95-164, §§ 101, 102, 103, 202, 203, 204, 205, 206, 301, 501, 502, 508 and PL 95-239 § 19 (30 USC 904), Federal Fire Prevention and Control Act, § 209, (29 U.S.C. 671(a)), Radiation Exposure Compensation Act, §§ 6 and 12(42 U.S.C. 2210), Housing and Community Development Act of 1922 §1021 (15 U.S.C. 2685), Energy Employees Occupational Illness Compensation Program Act (2000) 42 U.S.C. 7384, et. Seq. (as amended), Floyd D. Spence National Defense Authorization Act §§ 3611, 3612, 3623, 3624, 3625, 3626 of P.L. 106-393, National Defense Authorization Act for Fiscal Year 2006, PL 109-163, Toxic Substances Control Act (15 USC 2682), Prohibition of Age Discrimination Act (29 USC 623), Mine Improvement and New Emergency Response Act of 2006 (MINER Act), P.L. 109-236 (29 U.S.C. 671, 30 U.S.C. 963 and 965) §§ 6, 11 and 13

OCCUPATIONAL SAFETY AND HEALTH (DOLLARS IN THOUSANDS)	FY 2006 ACTUAL	FY 2007 CR	FY 2008 BUDGET	FY 2008 +/- FY 2007
BA	\$175,812	\$165,928	\$165,927	(\$1)
PHS Evaluation Transfers	\$87,071	\$87,071	\$87,071	\$0
Total	<b>\$262,883</b>	<b>\$252,999</b>	<b>\$252,998</b>	<b>(\$1)</b>

### STATEMENT OF THE BUDGET

The FY 2008 Budget of \$252,998,000 for Occupational Safety and Health reflects a decrease of \$1,000 below the FY 2007 Continuing Resolution of \$252,999,000.

### PROGRAM DESCRIPTION

Around the world, millions of men and women work in poor and hazardous conditions. Each year, more than two million people die of work-related accidents and diseases, and more than 160 million workers fall ill due to workplace hazards. The mission of CDC is to provide national and world leadership to prevent work-related injuries and illnesses among workers. CDC conducts research to reduce work-related injuries and illnesses and promotes safe and healthy workplaces through interventions, recommendations and capacity building.

To address this enormous challenge, CDC introduced its most significant collaborative effort, the National Occupational Research Agenda (NORA) in 1996. For the past ten years, NORA has served as a framework to guide occupational safety and health research - not only for CDC but for the entire occupational safety and health (OSH) community. NORA has resulted in a number of benefits, including:

- Concentrated efforts between government, academia, labor unions and industry that lead to faster, more effective implementation of OSH-related workplace solutions.
- Full integration of the CDC extramural research program into the National Institutes of Health (NIH) grants management system (known for its exemplary peer review standards and staffed by leading extramural scientists from the field of public health).

CDC has now entered the second decade of NORA (NORA II), building on past successes while preparing for new challenges in designing research to address the 21st century workplace. NORA II provides a framework for OSH research using a sector-based approach. CDC and its partners have formed eight Sector Research Councils and each is working to draft sector-based research goals, objectives, and action plans.

CDC has placed increased attention on the transfer and translation of research to practice. The NORA Research Councils will provide guidance to the entire OSH community on moving research findings, technologies, and information into highly effective prevention practices and products that are adopted in the workplace. CDC's goal is to reduce injury and illness by increasing workplace use of effective research findings. To achieve this, CDC continues to work with its partners to focus research on ways to develop effective products, to translate research findings into practice, to target dissemination efforts, and to evaluate and demonstrate the effectiveness of these efforts in improving worker safety and health.

CDC conducts research on the full scope of occupational illnesses and injuries: from basic research on mechanisms and etiology of occupational diseases to applied research on specific ways to prevent illness and injury in the workplace. Research is conducted both intramurally and extramurally, through cooperative efforts with a wide range of federal and non-federal partners. These efforts have been largely facilitated through the establishment of NORA, and CDC has aggressively aligned its intramural and extramural programs within the NORA framework. CDC intervention and recommendation activities bring tools, techniques, information, and procedures into the workplace that are intended to improve the health and safety of workers. CDC's capacity building efforts are meant to develop the capabilities of individuals and agencies in the field of occupational safety and health. This is accomplished through training and disseminating current and applicable occupational safety and health information to industry, workers, governments, and scientific and professional communities, both nationally and internationally. CDC's research efforts support the Secretary's 500-Day Plan's ideals of:

- Building interdisciplinary research teams that combine skills and knowledge from the biological, physical, and social sciences to yield biomedical insights that could not have been achieved by a single-discipline approach, and
- Interdisciplinary and interagency collaboration in scientific pursuits is the standard.

### **RATIONALE FOR THE BUDGET**

The FY 2008 Budget of \$252,998,000 for Occupational Safety and Health reflects a decrease of \$1,000 below the FY 2007 Continuing Resolution of \$252,999,000.

### **PERFORMANCE ANALYSIS**

#### **PART Results**

As a result of its 2004 PART review, the National Institute of Occupational Safety and Health (NIOSH) contracted with the National Academies (NA) to conduct a comprehensive review of its occupational safety and health research programs. Evaluation criteria were established by the NA Framework Committee in FY 2005. In FY 2006, a NA Evaluation Committee reported on the hearing loss program. The NA will report on the mining program in early FY 2007 and is currently in the process of reviewing the respiratory disease and agriculture programs. Results of these reviews will provide insight into the overall relevancy of the programs and the impact on occupational safety and health.

The Institute continues to implement the use of performance information to improve program direction, allocate resources and develop annual budgets. NIOSH has developed a structure to support the 30 programs of research within the Institute in order to properly align programs with performance goals. A program manager and coordinator will ensure the relevance of program goals and the scientific quality of the program's research activities. This team will also ensure that program outcomes have research-to-practice impact. Resource allocations for the 30 research programs will be determined based on the results of these activities, and reviewed on an annual basis. NIOSH is also continuing to track and assess performance on specific programs, including increasing accessibility of respirators to firefighters and first responders and reducing overexposure to respirable coal dust and fatalities and injuries in roadway construction.

The program is also participating in budget and performance integration efforts in accordance with CDC's agency-wide program planning, tracking and performance measurement system.

#### **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 2006, CDC funded ten Agricultural Safety and Health Centers that are located throughout the nation to be responsive to issues unique to the different regions.
- In 2006, 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.

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- CDC is the leading federal agency participating in an international effort to understand the health impact of nanotechnology and how to control potential occupational health effects. In 2005, CDC designated an additional \$0.5 million for the expansion of the Nanotechnology Health and Safety Program, under NORA. This initiative will study the toxicity and health impact of a range of nanomaterials. CDC is working with its national and international partners to develop a web-based Nanoparticle Information Library (NIL). This searchable database will help occupational health professionals, industrial users, worker groups, and researchers organize and share information on nanomaterials, including their health and safety-associated properties. In December 2006, CDC, the University of Cincinnati, and other partners sponsored the International Conference on Nanotechnology, Occupational and Environmental Health and Safety: Research to Practice. These efforts are part of a government-wide program to ensure that the U.S. will remain a world leader in nanotechnology research and development.
- Motor vehicle-related incidents are consistently the leading cause of work-related fatalities in the U.S. In response, CDC initiated the multidisciplinary Occupational Motor Vehicle Safety and Health Research Program under NORA to address topics such as ambulance crash survivability, the influence of fatigue in truck drivers, and the risk factors for vehicle crashes among public employees. CDC also actively engages employers to promote motor vehicle safety by providing technical assistance and disseminating Hazard Alerts and Fact Sheets that present practical prevention strategies in both English and Spanish.
- CDC translates and disseminates research findings for the occupational safety and health community. In 2004, CDC established the Office of Research 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. Now, all new research projects to be funded under NORA must be consistent with the research-to-practice principles.
- CDC responds to employer, employee, and state and local requests for worksite health hazard evaluations (about 400 each year). CDC assesses the workplace and health of employees by reviewing records and/or conducting on-site testing. These evaluations present the opportunity to obtain information on occupational exposures where standards are lacking, or do not protect all workers. After completion of the evaluations, CDC conducts follow-up surveys of participants to assess their satisfaction with the process and to learn whether the recommendations provided led to workplace improvements.
- CDC provides workplace-related safety and health information to employers, workers, industry, academia, the occupational safety and health community, and the general public through its English and newly implemented Spanish web sites.
- CDC increases workplace use of control and personal protective technology, particularly for emergency responders to chemical, biological, radiological, and nuclear (CBRN) terrorist events.

**Significant Accomplishments:**

- CDC and partners received the prestigious R&D 100 Award 2006 for development of the “Coal Dust Explosibility Meter – Model 100.” This is the first device ever created that provides an immediate capability for determining if coal dust concentrations in active areas of underground coal mines have been sufficiently mixed with rock dust to prevent risk of explosion. Technology used to date to assess coal dust concentrations require lab analysis that may take as long as two weeks to complete. The explosibility meter can be used to avoid this delay and enhance mine safety. The device is being manufactured and marketed for use in the field.
- CDC and partners developed a new method for detecting methamphetamine (meth) contamination to rapidly identify toxic exposures for police officers assigned to seize illegal meth labs. In 2005 alone, there were over 12,000 incidents in the U.S. involving meth labs. There are significant occupational risks of exposures to toxic materials for those entering sites contaminated with chemical wastes from meth production. The new meth wipe method provides faster and lower-cost identification of meth contamination on surfaces than existing methods, so that decisions on safe procedures and protective clothing for officers and other personnel can be made without delay. With the new method, results can be available in minutes compared with days for traditional methods.

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- CDC assisted in the development of the DHHS revised interim pandemic influenza planning guidance, issued October 17, 2006. The revised interim guidance includes updated and more precautionary recommendations regarding the use of surgical masks and respirators in health care settings during an influenza pandemic. CDC participated on the work group that developed the document, which includes a discussion of the science of influenza transmission, the capabilities of respirators and surgical masks, their use in circumstances in which there is a potential for exposure to airborne agents, and the rationale for adopting these more protective health care worker recommendations.
- Respirator Certification – CDC continues to conduct a respirator certification program to ensure respiratory protective equipment conforms to established regulatory standards, issuing 402 approvals in 2006. These include 30 respirators for occupational use by emergency responders against CBRN agents, of these 11 were self-contained breathing apparatus (SCBA), 10 air-purifying respirators, and nine air purifying escape respirators. CDC has initiated testing for Powered Air Purifying CBRN respirators with three applications in process. In addition, CDC is installing a CBRN Laboratory Respirator Protection Level testing chamber to improve the timing and decrease the expense of CBRN testing. CDC has also significantly decreased the approval times for new N95 respirators to increase the availability of filtering facepiece respirators.
- Noise-Induced Hearing Loss – Noise-induced hearing loss is one of the most common occupational diseases and the second most self-reported occupational illness or injury. Approximately 30 million workers are exposed to hazardous noise on the job, and an additional nine million are at risk for hearing loss from other agents such as solvents and metals. CDC engineers have designed and developed a new noise dosimetry system to assess and evaluate exposure to impulsive noise. Currently, commercial noise dosimeters are not capable of measuring exposure to impulsive noise accurately. The new dosimeter designed by CDC will enable OSH professionals to assess this potential hazard. CDC has partnered with a leading instrument manufacturer to implement the technology into their next generation of dosimeters.

**OUTPUT TABLE**

OUTPUT TABLE	FY 2006 ACTUAL	FY 2007 CR	FY 2008 BUDGET	FY 2008 +/ FY 2007
NORA Intramural Research Projects	255	255	255	0
Safety and Health Patent Filings	5	5	5	0
Certification Decisions Issued for Personal Protective Devices and Industrial Hygiene Instruments Evaluated for Certification	450	450	450	0
Estimated Academic Graduates	550	550	550	0
Hazard Evaluations/ Fatality Assessment and Control Evaluations	585	585	585	0
Number of Research Articles Published in Peer-Review Publications	200	200	200	0
Agricultural Centers	10	10	10	0
Number of States Receiving Public Assistance	35	35	35	0
Research Grants	180	180	180	0
Training Grants	55	55	55	0
CDC NIOSH Web site Visitors Sessions	7.6M	7.6M	7.6M	0

## GLOBAL HEALTH

### AUTHORIZING LEGISLATION

PHSA §§ 301, 304, 307, 310, 319, 327, 340C, 361-369, 2315, 2341: Foreign Assistance Act of 1961 §§ 104, 627,628: Federal Employee International Organization Service Act § 3: International Health Research Act of 1960 § 5: Agriculture Trade Development and Assistance Act of 1954 § 104: Economy Act: 22 U.S.C. 3968 Foreign Employees Compensation Program: 41 U.S.C. 253 International Competition Requirement Exception): P.L. 107-116 sec. 215: HR 5656 § 220 FY 2001 Appropriations Bill

GLOBAL HEALTH (DOLLARS IN THOUSANDS)	FY 2006 ACTUAL	FY 2007 CR	FY 2008 BUDGET	FY 2008 +/- FY 2007
BA	\$311,624	\$310,420	\$379,719	\$69,299
Department of Defense	\$68,000	\$0	\$0	\$0
Total	<b>\$379,624</b>	<b>\$310,420</b>	<b>\$379,719</b>	<b>\$69,299</b>

### STATEMENT OF THE BUDGET

The FY 2008 estimate of \$379,719,000 for Global Health reflects an increase of \$69,299,000 above the FY 2007 Continuing Resolution of \$310,420,000.

### PROGRAM DESCRIPTION

CDC has recently established three global health goals:

Health Promotion: recognizes the critical role CDC plays in sharing knowledge, tools and other resources with people and partners to promote health and prevent disease around the world. CDC addresses critical global public health challenges through working with a diverse set of partners to support the development and implementation of culturally-appropriate public health interventions. Through our health promotion activities, CDC will contribute to reductions in global morbidity and mortality.

Health Protection: seeks to ensure that Americans at home and abroad will be protected from health threats through a transnational prevention, detection and response network. To this end, CDC works with international partners to achieve rapid and accurate detection, diagnosis and verification of emerging global public health threats, and works to contain threats at their source to prevent international spread. In addition to making the world a safer and healthier place for all, CDC's health protection activities play a critical role in ensuring the health of Americans living and traveling abroad, and protecting U.S. economic interests.

Health Diplomacy: recognizes the important benefits that accrue to both the United States and the world through investments in public health capacity development and the creation of partnerships with the developing world. Through our health diplomacy activities, CDC and the United States Government will be a trusted and effective resource for health development and health protection around the globe. In cooperation with Ministries of Health (MOH) and other appropriate institutions, CDC assesses evolving global health issues and identifies and develops activities to apply CDC's technical expertise to be of maximum public health benefit.

CDC funds the Global AIDS Program (GAP), Global Immunization Program, Global Disease Detection (GDD) Initiative, Global Malaria Program, and other major Global Health activities. Funding for these international programs is contained within the Global Health budget activity. In addition to these programs, there are numerous other global public health efforts across CDC that complement and strengthen CDC's domestic public health efforts.

### GLOBAL AIDS PROGRAM

The challenges facing the developing world in seeking long-term solutions to prevent the transmission of HIV are daunting. The latest UNAIDS report estimates almost 40 million infected worldwide, including approximately 4.3 million new infections in 2006. Many nations face rapidly growing epidemics even as HIV/AIDS reduces average life spans. In January 2003, President Bush announced the President's Emergency Plan for AIDS Relief (known as the Emergency Plan, or PEPFAR) and called on Congress to provide an unprecedented \$15 billion, multifaceted approach to combating the disease around the world.

As an implementing partner of the Emergency Plan, CDC/GAP supports HIV/AIDS prevention, care and treatment programs in more than 50 countries worldwide. GAP plays a vital role in helping to meet the PEPFAR goals of preventing seven million new HIV infections, supporting treatment for two million HIV-infected persons, and supporting care for ten million individuals infected or impacted by HIV. When the Emergency Plan was announced in 2003, there were only 50,000 patients on antiretroviral treatment in all of sub-Saharan Africa. As of September 2006, PEPFAR has supported treatment for more than 822,000 people in the 15 focus countries.

As part of coordinated interagency US Government (USG) teams implementing PEPFAR, GAP has highly trained physicians, epidemiologists, public health advisors, behavioral scientists, and laboratory scientists working in offices in 29 countries (including the 15 PEPFAR focus countries). GAP supports more than 25 additional countries through its headquarters and regional offices. In partnership with host governments, ministries of health, non-governmental organizations, international organizations, U.S.-based universities, and the private sector, GAP assists with HIV prevention, care and treatment; laboratory capacity building; surveillance, monitoring and evaluation; and public health evaluation research. GAP supports the Global Fund to Fight AIDS, Tuberculosis and Malaria and has technical staff working in the Office of the Global AIDS Coordinator, USAID, and the HHS Office of Global Health Affairs in Washington, D.C., as well as the World Health Organization (WHO) and UNAIDS. GAP is uniquely positioned to coordinate with CDC's other global health programs, such as global disease detection, public health training, and prevention and control of other infectious diseases such as malaria and tuberculosis, as well as with CDC's domestic HIV/AIDS prevention programs in the United States.

#### ***GLOBAL IMMUNIZATION PROGRAM***

CDC supports global immunization initiatives to protect American children from vaccine-preventable diseases imported into the United States or acquired abroad, for humanitarian reasons, and to protect against the medical costs of morbidity and mortality associated with vaccine-preventable diseases. CDC priorities in FY 2008 are global polio eradication, measles mortality reduction and regional measles and rubella elimination, and strengthening childhood immunization programs in developing countries. CDC supports these initiatives by providing epidemiologic, laboratory, and programmatic support to the WHO and United Nations Children's Fund (UNICEF), by assigning expert staff overseas to help implement global immunization programs, and providing short-term technical assistance abroad through temporary assignments of CDC experts from Atlanta.

CDC provides extensive financial support through WHO, UNICEF, the Pan American Health Organization (PAHO) and the United Nations Foundation, most notably for procurement of measles and polio vaccine through UNICEF. CDC operates in partnership with public and private sector partners to achieve global immunization objectives including Rotary International, American Red Cross, United Nations Foundation, International Federation of Red Cross and Red Crescent Societies, Bill and Melinda Gates Foundation, WHO, UNICEF, and World Bank. The overall number of polio cases has been reduced from more than 350,000 polio cases annually in 1988 to 1902 cases to date in 2006 (as of 9 January 2007). More than 200 countries and territories are polio free and the disease is now endemic in four countries in the world: Nigeria, India, Pakistan and Afghanistan. In 2006, more than 94% of all cases detected globally have been from the endemic countries, with 58% from Nigeria and 33% from India alone. Additionally, 12 countries have reported polio cases in 2006 due to importations and subsequent transmission (Angola, Bangladesh, Cameroon, DR Congo, Ethiopia, Indonesia, Kenya, Namibia, Nepal, Niger, Somalia and Yemen). Significant progress has been made in achieving the goal to reduce global measles-related mortality by 50% between 2001 and 2005. The goal was achieved ahead of schedule and under budget by immunizing over 200 million children in 33 countries and saving over a million lives since mid-2001.

#### ***GLOBAL DISEASE DETECTION***

As demonstrated with the SARS outbreak, a highly pathogenic infectious disease in a remote region of the world can spread around the world in a matter of days or weeks. GDD program aims to protect the health of Americans and others by establishing a series of GDD Response Centers around the world. These GDD Response Centers are collaborations with the host country and WHO that will strengthen regional capacity to rapidly detect and effectively respond to infectious disease outbreaks - whether the cause is an intentional act of terrorism or the natural emergence of a deadly infectious pathogen - before they spread.

In support of the Secretary's 500 Day Plan and the new International Health Regulations, these GDD Response Centers will expand the international network of early warning infectious disease surveillance centers, respond to outbreaks, conduct research, build local epidemiology and laboratory capacity, and establish a novel global network. Key to this effort are enhanced capabilities in disease detection and response in "strategic partner" countries, a connected and secure information technology infrastructure, and improved pandemic influenza preparedness and response. To organize this initiative, CDC is employing proven and effective interventions, including Field Epidemiology Training Programs (FETP) and International Emerging Infections Programs (IEIP). GDD helps to ensure that countries have ready access to the resources needed to detect and contain global disease threats, and represents the U.S. contribution to helping countries acquire the required capacities to identify, report, and contain

public health threats as outlined in the revised International Health Regulations. Having CDC staff on the ground has been invaluable in providing initial response support for threats such as the SARS outbreak of 2003, the December 2004 tsunami, and the avian influenza threat of 2004-2006.

#### **GLOBAL MALARIA PROGRAM**

Globally, malaria transmission occurs in more than 100 countries. Malaria was declared eradicated in the U.S. in the late 1950s, but up to 1,400 people in the U.S. get malaria each year from travel to places where malaria transmission is occurring. Each year approximately 20 million U.S. travelers must use malaria prevention medicines, and an estimated 50,000 U.S. blood donors are rejected because of concern about malaria transmission via the blood supply. In endemic countries, malaria kills a child approximately every 30 seconds, causes more than one million deaths and 500 million infections each year, is increasingly resistant to available medicines for treatment and to prevent infection in travelers, and gross domestic product is up to 20 percent lower than it would have been if there had been no malaria during the last 15 years. Malaria, along with HIV/AIDS and TB, is a destabilizing factor and continues to pose a critical threat to the national security of all sub-Saharan African countries. The U.S. is committed to helping these governments address this crisis.

On June 30, 2005, President Bush announced a five-year, \$1.2 billion U.S. Government initiative to reduce malaria mortality by 50 percent in up to 15 African countries with a population of 175 million. The President has challenged other countries to join this initiative and contribute another \$4.2 billion over five years to include 20 more countries with a population of 420 million. The program will support national malaria control programs to achieve 85 percent coverage with known effective strategies including prompt and effective treatment, insecticide-treated bednets (ITNs) and insecticide indoor residual spraying, and preventive treatment for pregnant women.

CDC supports prevention and control of malaria throughout the world in partnership with local, state, and federal agencies in the United States; medical and public health professionals; national and international organizations; and foreign governments by:

- Conducting malaria surveillance, prevention, and control activities in the United States;
- Providing consultation, technical assistance, and training to malaria endemic countries to change and implement proven policies to decrease malaria burden;
- Conducting multidisciplinary research in the United States and internationally, in the laboratory and in the field, to develop new tools and improve existing interventions against malaria worldwide; and,
- Translating research findings into appropriate global policies and effective practices through the Roll Back Malaria Consortium and other international partners.

#### **OTHER GLOBAL HEALTH ACTIVITIES**

##### **FIELD EPIDEMIOLOGY (& LABORATORY) TRAINING PROGRAM (FE(L)TP)**

In collaboration with national and international organizations (e.g., the Department of State, USAID, WHO, and the World Bank), the FE(L)TP helps foreign Ministries of Health build strong, sustained public health systems, tailored to the unique needs of each country. CDC's role is to provide training and technical assistance to health professionals around the globe, as well as capacity building to assess disease surveillance and improve intervention programs. The FE(L)TP programs cover a broad range of issues, including epidemiology, investigation of infectious and non-infectious health problems, health surveillance systems, applied economics, communications science, and resource management. Through these programs, foreign Ministries of Health acquire the means to build their own programs and capacity to improve public health on a local, regional, and national level, ultimately leading to improved health on a global scale.

The FE(L)TP strategy is to help countries implement sound, effective, public health programs through:

- Service: epidemiological services to the public health system at national and sub-national levels.
- Training: self-sustaining institutionalized capacity to train public health leaders in the field of epidemiology.
- Systems: strengthening public health surveillance and information systems.

This strategy is implemented by helping countries set up applied epidemiology and laboratory training programs, modeled after CDC's Epidemic Intelligence Service and CDC's public health laboratory practice training programs.

#### **SUSTAINABLE MANAGEMENT DEVELOPMENT PROGRAM (SMDP)**

The goal of SMDP is to assist developing countries in improving the effectiveness of public health programs by empowering local health officials with better management skills, and by stimulating creativity and innovation in problem-solving among local health personnel. The SMDP strategy includes working with international donor partners to provide technical assistance to public health professionals as they establish in-country management training programs. Technical assistance focuses on 1) needs assessment; 2) curriculum development; 3) marketing, organizing, and teaching workshops; and 4) supervising applied learning projects.

#### **RATIONALE FOR THE BUDGET**

The FY 2008 estimate of \$379,719,000 for Global Health reflects an increase of \$69,299,000 above the FY 2007 Continuing Resolution of \$310,420,000.

##### Pandemic Influenza (+\$69.3 million)

The FY 2008 President's Budget includes support for the following pandemic influenza activities:

###### Rapid Outbreak Response for High Priority Countries (+\$17.8 million)

When a potential pandemic influenza strain is identified, swift and decisive action can make the difference between whether the strain is contained or spreads globally. Based on the available epidemiologic information, CDC will continue to identify countries at high risk for the emergence of a potential pandemic in need of monitoring efforts and help develop in-country response teams. The goal is to have four to five member teams trained to undertake emergency field epidemiology studies, collect samples for shipment to laboratories, dispense antiviral medications, and institute emergency control measures – such as quarantine stations – in a standardized manner. Funds in the FY 2008 President's Budget will allow CDC to enhance activities undertaken with funding in FY 2006 to ensure the target countries are monitored and safeguarded from disease spread that could elevate to pandemic levels.

###### Human-Animal Interface Studies (+\$4.0 million)

To complement National Institutes of Health epidemiological studies, CDC will enhance FY 2006 activities in the FY 2008 President's Budget by continuing to support studies that examine the risk and frequency of human infections with animal influenza A viruses that have pandemic potential. CDC will analyze epidemiologic case control studies of risk factors for severe disease and cross sectional seroprevalence studies of antibodies of H5N1 virus in different risk populations. Risk populations may include people with occupational exposure to poultry; persons living in rural areas in close contact with poultry and pigs; persons involved in poultry culling activities; and health care workers who have cared for H5N1 patients.

###### International Surveillance, Diagnosis, and Epidemic Investigations (+\$47.5 million)

With increased funding in FY 2008, CDC will enhance efforts to address pandemic influenza preparedness gaps through increasing laboratory capacity and technical support at local levels; assisting in the development of surveillance, diagnosis, and epidemic investigations; and assisting the WHO in creating and maintaining proper coordinating and monitoring infrastructure in high risk countries.

#### **PERFORMANCE ANALYSIS**

##### PART Results

The Global Immunization Program is continuing to develop performance tracking and measurement systems in accordance with CDC's program measurement software database. The program is currently undergoing revisions and additions of project information within the software system for the 2007 fiscal year. Ongoing edits will continue as resource ceilings are allocated, awards are completed and performance information is received and analyzed. Evaluations are also being developed, specifically for management of measles activities at domestic headquarters. These evaluations will provide insight on increased cost and staff efficiencies and performance tracking and measurement to improve the overall program.

Current Activities

Global AIDS Program (GAP):

- Implementing the Emergency Plan in coordination with the Department of Health and Human Services' Office of Global Health Affairs, the Department of State's Office of the Global AIDS Coordinator and other US government agencies with the goal of preventing seven million new HIV infections, treating two million HIV-infected people, and caring for ten million persons living with HIV/AIDS and AIDS orphans.
- Developing national HIV care and treatment and prevention of mother-to child (PMTCT) scale-up plans, policy guidelines, monitoring systems and standardized training programs in collaboration with host nation ministries of health.
- Strengthening in-country capacity to conduct HIV/AIDS surveillance through epidemiologic investigations, and financial and technical assistance for strengthening and maintaining HIV-related information systems, and monitoring and evaluating HIV prevention, care and treatment initiatives.
- Developing and helping to implement guidelines in collaboration with WHO on the prevention of tuberculosis in health care facilities in resource-limited settings.
- Strengthening the capacity of host nation laboratory systems at the local, regional and national level to adequately support scale up of HIV prevention, treatment and care activities.
- Developing standardized training curriculums to support scale up of high quality HIV rapid testing in under-resourced settings.
- Developing and sharing effective program models to prevent the transmission of HIV from infected individuals to their partners and families through technical assistance to the field, promotion of evidence-based approaches, and proposed targeted evaluations of clinic and community based models of intervention.
- Providing management and technical assistance to National Blood Transfusion Services to ensure a safe and sufficient blood supply and training of health workers in prevention of medical transmission and safe blood practices.

Global Immunization:

- Providing funds through UNICEF and the UN Foundation (UNF) for the purchase of polio and measles vaccines, and for conducting supplemental immunization activities (SIAs).
- Providing immunization technical assistance to WHO and UNICEF in polio and measles endemic countries through the deployment of CDC epidemiologists and public health experts, and recruiting and training health professionals for Stop Transmission of Polio (STOP) teams.
- Conducting surveillance to monitor and direct polio eradication and measles mortality reduction efforts, certifying the eradication of polio, and helping to build the laboratory platform for detection and surveillance of polio, measles, and other diseases.
- Continuing the Measles Initiative in African countries and expanding to Asia to support WHO's 47 priority countries and the Global Immunization Vision and Strategy goal to reduce measles deaths by 90% globally by 2010 (compared with 2000 figures). The goal of 50 percent reduction in measles mortality globally by 2005 was met.
- Providing immunization technical assistance to WHO and UNICEF in rubella endemic countries through the deployment of CDC epidemiologists and public health experts.
- Assisting the WHO in building global polio and measles laboratory networks and helping build the platform for detection of other diseases.

Global Disease Detection:

- Establishing GDD Response Centers that integrate disease surveillance, applied research, prevention and control activities in strategic countries, to improve the ability to detect and control new and emerging infectious threats at their source.
- 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.
- Integrating international data collection and enhancing information synthesis activities to improve CDC's capability to detect emerging threats at their source.

- Developing a functioning global network to enhance synergies and leverage resources.

Global Malaria Program:

- Conducting national malaria surveillance, providing technical assistance to clinicians caring for patients with malaria, and establishing prevention and treatment guidelines for U.S. travelers and clinicians.
- Providing technical assistance, including monitoring and evaluation, to WHO, the World Bank, UNICEF, UNF, and USAID in malaria endemic countries in Africa, Asia, and the Americas in support of the global Roll Back Malaria program and the Global Fund to Fight AIDS, Tuberculosis, and Malaria.
- Supporting universities and other investigators for malaria research including: the development of novel antimalarial drugs to address the growing problem of drug resistant malaria, evaluating improved ITNs, preventive intermittent treatment for pregnant women and infants, the impact of artemisinin-containing combination drug regimens, the interaction of HIV and malaria and mosquito larval ecology for the reduction of vector breeding.
- Collaborating with Liverpool School of Tropical Medicine, the Kenya Medical Research Institute, the Ifakara Health Research and Development Center in Tanzania, the Malaria Research and Training Center in Mali, the Malaria Research Center in India, and other institutions to strengthen international collaborative efforts to identify, evaluate, and implement malaria control strategies in sub-Saharan Africa and Asia.
- Working in partnership with USAID to implement the President's Malaria Initiative including leadership in monitoring and evaluation of malaria control scale-up activities.
- Providing technical assistance in the design, implementation, analysis, and interpretation of surveys to measure the impact of integrated child health campaigns (immunizations and bednets) in malaria endemic countries in Africa and elsewhere.

Other Global Health:

- Assisting with establishing surveillance for viral respiratory disease in camps with Asian refugees emigrating from areas of widespread avian influenza transmission.
- Assisting with field investigation of human avian influenza cases in northern Thailand.
- Rapidly deployed FE(L)TP trainees to assist with the response to avian influenza outbreaks in birds in Nigeria.
- Developed an avian influenza module and conducted training-of-trainers workshop for participants from seven Asian countries (Thailand, Vietnam, Cambodia, Laos, Malaysia, India, and China).
- Strengthening non-communicable disease surveillance capacity in China, Brazil, and Jordan, to respond to national priorities in those countries such as diabetes, obesity, and environmental health issues.
- Collaborated with the Ministry of Health in Uzbekistan and US Department of Defense, Defense Threat Reduction Agency to improve the sensitivity of public health surveillance for the detection of disease due to potential bioterror pathogens through training of epidemiologists, laboratory scientists, and improvement of laboratory infrastructure.
- Conducts a six-week course through the SMDP for trainers from developing countries built upon a public health management competency framework that comprises the six principal and interrelated domains of leadership, communication, team building, planning and priority setting, performance assessment and problem solving.

Significant Accomplishments

Global AIDS Program (GAP):

- In 2006, provided technical assistance and support for programmatic activities (e.g., prevention, laboratory capacity, surveillance, PMTCT and care and treatment in 29 GAP countries; assigned over 100 CDC staff to the field; and employed over 1,000 local staff to implement country programs).
- As of September 2006, supported PEPFAR in providing life-saving antiretroviral treatment for approximately 822,000 men, women and children through bilateral programs in PEPFAR's 15 focus countries in sub-Saharan Africa, Asia and the Caribbean.
- Through September 2006, supported PEPFAR in providing antiretroviral prophylaxis for women during 533,700 pregnancies, and supporting the prevention of an estimated 101,500 infant HIV infections.

- As of September 2006, supported PEPFAR in providing 18.7 million counseling and testing sessions for men, women and children.
- Through September 2006, supported PEPFAR in providing HIV care for nearly 4.5 million individuals.
- In 2006, provided HIV surveillance training to over 200 individuals from 20 countries.
- Worked with WHO to develop a comprehensive HIV Rapid Testing Training Package.
- Developed guidelines in collaboration with WHO on the prevention of tuberculosis in health care facilities in resource-limited settings.
- Developed and implemented PEPFAR.net (<http://www.pepfar.net>), which is a secure, virtual collaborative community that connects staff from seven USG agencies implementing PEPFAR located in offices around the world. PEPFAR.net is fostering the interagency coordination that is the hallmark of PEPFAR in order to save and improve the lives of as many people impacted by HIV as rapidly as possible.

Global Immunization Program:

- Prevented five million cases of childhood paralysis and saved an estimated 250,000 lives since the global polio eradication initiative began in 1988.
- Reduced the number of polio cases from more than 350,000 in 1988 to 1902 cases to date in 2006 (as of January 2007). Today, more than 200 countries and territories are polio free and the disease is now endemic in four countries in the world: Nigeria, India, Pakistan and Afghanistan. In 2006, more than 94% of all cases detected globally have been from these four countries, with 58% from Nigeria and 33% from India alone. Additionally, 12 countries have reported polio cases in 2006 due to importations and subsequent transmission (Angola, Bangladesh, Cameroon, DR Congo, Ethiopia, Indonesia, Kenya, Namibia, Nepal, Niger, Somalia and Yemen).
- Development of new laboratory procedures which can detect and confirm new polio infection twice as quickly, enabling a more rapid outbreak response.
- Met the World Health Assembly endorsed goal to reduce global measles-related mortality by 50% between 2001 and 2005. Measles mortality in the African region has been reduced by 74% since 1999 and measles mortality worldwide has been reduced by 60 percent. The goal was achieved ahead of schedule by immunizing over 200 million children in 33 countries and saving over a million lives since mid-2001.
- Reduced by more than 99 percent the number of measles cases in the Western Hemisphere from approximately 250,000 in 1990 to 186, all of which are associated with imported viruses (as of December 2006).
- Investigating measles outbreaks in the Republic of Georgia, Kenya, Pakistan, Sudan, the Republic of the Ukraine and Fiji.
- Met the World Health Assembly endorsed goal to reduce measles related mortality in Africa by 50% between 2001 and 2005. The goal was achieved ahead of schedule and under budget by immunizing over 200 million children in 33 countries and saving over a million lives since mid-2001.

Global Disease Detection:

- Investigated more than 60 disease outbreaks, including cases of avian influenza, hemorrhagic fever, meningitis, cholera, and unexplained sudden death, through established GDD Response Centers in Kenya, Thailand, China, Guatemala and Egypt.
- Responded with CDC staff and antitoxin to one of the largest reported outbreaks of botulism in Thailand.
- Trained 20 laboratory scientists from 14 countries in Africa on testing and confirmation of highly pathogenic avian influenza virus, and trained staff from 13 sub-Saharan countries on pandemic flu preparedness and response.
- Trained 8-person teams from Ministries of Health, Agriculture, and Education and Community Information and Pandemic Influenza Planning in avian and pandemic influenza risk communication. Teams came from Cambodia, China, Indonesia, Laos, Thailand and Vietnam.
- Trained over 100 rapid responders from 14 countries in attempted containment of a mounting pandemic during the first 72-hours of a respiratory diseases cluster that might become a possible pandemic.
- Synchronized community-based surveillance protocols in Guatemala with sites in Thailand and Kenya to enable cross-country comparison of data.

- Strengthened capacity to detect and diagnosis rapidly spread respiratory disease outbreaks, allowing for effective containment before posing a serious threat to the U.S. population.
- Expanded capacity to detect and control multi-drug resistant tuberculosis among US-bound refugees and other populations.
- Improved access to safe water, sanitation and hygiene in Latin America and the Caribbean.
- The Global Salm-Surv project builds capacity for enteric disease laboratory-based surveillance and global response, primarily through international training courses in epidemiologic and laboratory-based methods. Activities were expanded to China and Thailand.
- The success of the PulseNet program to detect outbreaks of foodborne illness has only recently been replicated in other countries. PulseNet International activities were increased in Latin America and Asia. Preliminary meetings were held in the Middle East to determine the usefulness of PulseNet in that region.
- A novel assay for detecting histoplasmosis using urine samples is currently being evaluated and validated. Such a rapid and affordable method would allow for earlier treatment, decreasing both morbidity and mortality.

Global Malaria Program:

- Collaborated with Roll Back Malaria partners on the development of the African Strategic Framework for Malaria Prevention in Pregnancy and provided financial support and/or technical assistance for malaria program implementation in 14 countries and seven regional networks in Africa.
- Completed data collection in Tanzania and presented preliminary findings at an international conference in the U.S. on a comprehensive evaluation of the impact of artemisinin containing combination anti-malarial therapy, which will inform treatment policies in Africa.
- Conducted a field study in Kenya that demonstrated durability and effectiveness of different long-lasting-treated nets (LLIN) and provided the information to WHO to inform LLIN recommendations.
- Assisted in the evaluation of an integrated child health campaign that delivered different long-lasting-treated bednets with immunizations and other preventive measures in Kenya, Mozambique, and Niger. These campaigns dramatically increased national coverage with these life-saving interventions and help to address health equity disparities.
- Provided 87 on-site technical consultations to 24 countries and numerous partner organizations on malaria-control activities and implementation of research projects.
- In partnership with experts from WHO, UNIDSEF, the Global Fund, USAID, the World Bank, and prominent universities completed projects to estimate malaria mortality in African children and to evaluate the impact of malaria control efforts on mortality in Africa.
- Provided, in partnership with USAID assessments and strategic planning with the national malaria control programs in the President's Malaria Initiative (PMI) new Year 2 countries: Senegal, Mozambique, Rwanda, and Malawi, to begin the scale-up of interventions. Continued to support implementation and evaluation activities in the three Year 1 countries: Angola, Uganda, Tanzania.
- Assisted the Kenya Ministry of Health to conduct an evaluation of malaria rapid diagnostic tests for the scale-up of national Malaria Control Program in support of the President's Malaria Initiative.
- Assisted Zambia in conducting and evaluating a national survey on malaria prevention and treatment coverage as well as indicators of malaria infection and anemia prevalence.

Other Global Health:

- Provided a Resident Advisor for consultation and support to 28 FE(L)TPs and similar programs, in 37 countries from 1980 to 2006. Of these, 19 no longer need support from a full-time Resident Advisor and 19 countries are still producing graduates. During this 26 year period, more than 1,200 epidemiologists have graduated from these programs.
- Increased the number of international sites with the capacity to conduct disease identification and intervention activities by building FETPs in collaboration with Ministries of Health in China, Kenya, Central America, Central Asia, Jordan, Thailand, India, and Brazil, and initiating new programs in South Sudan, Pakistan, and South Africa.

- Awarded assessment contracts to improve connectivity among all the CDC offices worldwide and worked directly with the Department of State and proactively advised HHS on matters related to costs associated with the State Department's new Capital Security Cost Sharing initiative.
- During FY07, the SMDP will be responding to requests for new program efforts in the following countries: Botswana; Brazil; Ethiopia; Indonesia; Malawi; Mozambique; and Taiwan. SMDP's ongoing programs will continue with established partners in Botswana, Croatia, Guam, Lesotho, Macedonia, Malawi, the Philippines, Saipan, Serbia, Swaziland, Thailand, Uganda, Vietnam and Zambia.
- Established a small pilot program for expanded overseas health assessment and treatment for U.S.-bound refugees, which has proved successful for target groups of refugees and specific conditions, such as malaria, intestinal parasites, and tuberculosis and multi drug-resistant tuberculosis.

### **OUTPUT TABLE**

OUTPUT TABLE <sup>1</sup>	FY 2006 ACTUAL	FY 2007 CR	FY 2008 BUDGET	FY 2008 +/ FY 2007
Global HIV/AIDS				
<b>Focus Countries – The numbers below reflect total USG efforts contributed to by CDC<sup>2</sup></b>				
Number of individuals receiving HIV/AIDS treatment in the 15 focus countries	822,000	860,000	1,300,000	440,000
Number of countries conducting surveillance	15	15	15	0
<b>Other Bilateral Country Programs – The numbers below reflect total USG efforts contributed to by CDC<sup>3</sup></b>				
Number of countries conducting surveillance	9	9	9	0
Number of persons trained in the provision of laboratory-related activities	1,130	1,370	1,370	0
Global Immunization Activities				
Number of measles vaccine doses purchased for use internationally	66M	66M <sup>3</sup>	66M	0
Global Malaria Program				
Number of countries receiving technical assistance in malaria control scale-up through the President's Malaria Initiative (PMI)	3	7	15	8
Number of non-PMI countries receiving technical assistance for malaria research and control activities	10	10	10	0
Global Disease Detection				
Number of "Strategic Partner" countries with disease detection and response interventions	5	5	5	0
Other Global Health				
Number of countries receiving funds for international influenza	35-40	35-40	35-40	0

<sup>1</sup>Outputs for Focus Countries are a result of the USG effort to stem the tide against the global HIV/AIDS epidemic. As part of PEPFAR, CDC contributes to this effort, but the data provided is indicative of the USG effort as a whole.

<sup>2</sup>Outputs for Other Bilateral Countries are a result of the USG effort to stem the tide against the global HIV/AIDS epidemic. As part of PEPFAR, CDC contributes to this effort, but the data provided is indicative of the USG effort as a whole.

<sup>3</sup>Significant cost increases in measles vaccines are not expected, and thus purchase numbers are estimated to remain steady. If costs do increase, purchases will decline accordingly.

FUNCTIONAL TABLE

GLOBAL HEALTH (DOLLARS IN THOUSANDS)	FY 2006 ACTUAL	FY 2007 CR	FY 2008 BUDGET	FY 2008 +/- FY 2007
Global AIDS Program	\$122,560	\$121,224	\$121,223	(\$1)
Global Immunization Program	\$144,282	\$144,383	\$144,383	\$0
Global Disease Detection	\$32,443	\$32,466	\$32,466	\$0
Global Malaria Program	\$8,975	\$8,981	\$8,981	\$0
Other Global Health	\$71,364	\$3,366	\$72,666	\$69,300
Total	\$379,624	\$310,420	\$379,719	\$69,299

## PUBLIC HEALTH RESEARCH

### AUTHORIZING LEGISLATION

PHSA §§ 301, 304, 307, 310, 317, 327

PUBLIC HEALTH RESEARCH (DOLLARS IN THOUSANDS)	FY 2006 ACTUAL	FY 2007 CR	FY 2008 BUDGET	FY 2008 +/- FY 2007
PHS Evaluation Transfers	\$31,000	\$31,000	\$31,000	\$0

### STATEMENT OF THE BUDGET

The FY 2008 Budget of \$31,000,000 for Public Health Research reflects level funding with the FY 2007 Continuing Resolution.

### 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 FY 2004 as a multi year program that promotes much needed research in critical public health areas addressing CDC's health protection goals:

- Healthy People in Every Stage of Life
- Healthy People in Healthy Places
- People Prepared for Emerging Health Threats
- Healthy People in a Healthy World

The focus in FY 2004 was to support research on developing effective health promotion and prevention programs at the workplace and to support new training efforts and new centers of excellence. The workplace affords opportunities to reach employees to promote their health in order to reduce absenteeism and health care costs associated with preventable chronic diseases.

In FY 2005, this program addressed the need for an interdisciplinary approach to research in health marketing and health communication and in public health informatics by funding two centers of excellence in each of these areas. These new centers will conduct research in applied settings, including community, regional, and national settings and to build interdisciplinary research teams that include economists, educators, informaticians, mathematicians, marketing and communications specialists, public health practitioners, and others, to address critical research needs. The two Centers of Excellence in Public Health Informatics conduct interdisciplinary research that will lead to major scientific advances in knowledge, implementation and new applications in public health informatics to promote effective public health practice. The two Centers of Excellence in Health Marketing and Health Communication will develop interdisciplinary approaches that promote the spread and adoption of effective public health interventions.

In FY 2006, one new Center of Excellence in Health Marketing and Health Communication was added and continuation awards for year two (centers funded in FY 2005) and year three (projects, training, institutional training, and centers funded in FY 2004) of the HPRI projects were funded. In FY 2007, the funding period will end for the grants awarded in FY 2004. Funds will be used to support three graduate training program grants initially awarded in FY 2004. These grants provide support for training activities related to the development or enhancement of training programs that provide research training opportunities for individuals, selected by the institution, who are training for careers in specified areas of health protection research. Funds will also be recycled into new grant awards that: 1) develop implementation and diffusion research to address the CDC Health Protection Goals (healthy people, healthy places, people prepared, and healthy world); 2) translate the findings of the FY 2004 HPRI workplace health promotion studies; and 3) provide funds to young investigators and doctoral student dissertations in public health research. In FY 2008, CDC will support new research initiatives that address the elimination of health disparities.

CDC is committed to funding high-quality public health research that makes the transition from research to practice. All research is proposed by researchers working with communities, health practitioners, and policymakers to address local priority health concerns. All research projects also undergo peer review by expert researchers external to CDC to identify the highest quality proposals. Research awards are evaluated at least annually by program officials to determine if adequate progress is made. CDC promotes interagency collaboration in scientific pursuits by publishing the Health Protection Research Initiative funding opportunity announcements in the NIH Guide for Grants and Contracts and Grants.gov so that CDC and NIH are able to participate jointly in initiatives and where scientists can

find competitive funding opportunities for both agencies. CDC also participates in the NIH Early Notification System that circulates program announcements to all NIH Institutes and Centers to encourage co-sponsoring of research initiatives prior to publication.

### **RATIONALE FOR THE BUDGET**

The FY 2008 Budget of \$31,000,000 for Public Health Research reflects level funding with the FY 2007 Continuing Resolution.

### **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 funded continuation awards for years two and three of the HPRI and continue program evaluation efforts. In addition, one new Center of Excellence in Health Marketing and Health Communication was funded. CDC will develop a Program Announcement for translation and dissemination research to address the CDC Health Protection Goals.
- In FY 2007, CDC will fund continuation awards for year three of the four centers of excellence, new awards to support three graduate training program grants initially awarded in FY 2004, new awards for FY 2007 that are aligned with the CDC health protection goals, and new awards for implementation and diffusion research, young investigators, and translation of FY 2004 HPRI workplace health promotion studies.
- In FY 2007, CDC will build upon the long-range research priorities set forth in its Advancing the Nation's Health: A Guide to Public Health Research Needs, 2006-2015 (referred to as Research Guide), to develop a health protection research agenda of shorter-term research priorities and initiatives.
- In FY 2008, CDC will support new research initiatives that address the elimination of health disparities.

### **Significant Accomplishments**

- In FY 2004, CDC awarded 58 extramural research grants to support research on developing effective health promotion and prevention programs at the workplace and to support new training efforts and new centers of excellence in health promotion economics. These awards were made using four mechanisms of support totaling \$22 million.
- CDC has developed the first national public health Research Guide with extensive involvement from external partners and stakeholders, including researchers, other federal agencies, state and local health departments, professional associations, universities, non-governmental organizations, business and worker organizations, private citizens, community groups, tribal leaders and organizations, and the public-at-large. The Research Guide will serve as a critical resource for research areas that should be addressed during the next decade by CDC and its partners in response to current and future health needs and events. The Research Guide is aligned with new health protection goals providing direction for future research.
- In FY 2005 and FY 2006, Principal Investigators of the HPRI grants met in Atlanta to discuss how to best identify the impact of their research on public health practice and on policy.
- In FY 2005, CDC awarded four centers of excellence grants: two in Public Health Informatics and two in Health Marketing and Health Communication.
- In FY 2006, CDC awarded one new Center of Excellence in Health Marketing and Health Communication.
- CDC is standardizing best practices for extramural research across CDC, similar to those used by NIH and also meets all HHS standards and guidelines.
- Extramural Research Program Offices have been added to the new CDC Coordinating Centers and they provide services to the National Centers.
- CDC solicits public health research and research training and selects the most highly meritorious applications through external peer review. In FY 2005, CDC met its 90 percent goal of all research applications having external peer review, and in FY 2006 achieved the 100 percent goal.
- 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.

**OUTPUT TABLE**

OUTPUT TABLE	FY 2006 ACTUAL	FY 2007 CR	FY 2008 BUDGET	FY 2008 +/- FY 2007
Extramural health promotion research grants:				
New awards	1	74	41	(33)
Continuation awards	60	5	48	43

## **PUBLIC HEALTH IMPROVEMENT AND LEADERSHIP**

### **AUTHORIZING LEGISLATION**

PHSA §§ 301, 304, 306, 307, 308, 310, 311, 317, 317(F), 319, 319A, 322, 325, 327, 352, 361 -369, 391, 399(F), 399G, 1102, 2315, 2341: Federal Technology Transfer Act of 1986, (15 U.S.C. 3710): Bayh-Dole Act of 1980, P.L. 96-517: Clinical Laboratory Improvement Amendments of 1988, § 4

<b>PUBLIC HEALTH IMPROVEMENT AND LEADERSHIP (DOLLARS IN THOUSANDS)</b>	<b>FY 2006 ACTUAL</b>	<b>FY 2007 CR</b>	<b>FY 2008 BUDGET</b>	<b>FY 2008 +/- FY 2007</b>
BA	\$189,106	\$189,236	\$190,412	\$1,176
Department of Defense	\$75,000	\$0	\$0	\$0
<b>Total</b>	<b>\$264,106</b>	<b>\$189,236</b>	<b>\$190,412</b>	<b>\$1,176</b>

### **STATEMENT OF THE BUDGET**

The FY 2008 Budget of \$190,412,000 for Public Health Improvement and Leadership (PHIL) reflects an increase of \$1,176,000 above the FY 2007 Continuing Resolution of \$189,236,000.

### **PROGRAM DESCRIPTION**

The PHIL budget activity supports several cross-cutting areas within CDC whose purposes are to ensure more efficient and effective science and program development. This activity includes the Leadership and Management function, which funds the CDC Office of the Director (OD), coordinating centers, and each constituent center. The PHIL budget activity also supports CDC's newly coordinated workforce and career development efforts. Additionally included are the Director's Discretionary Fund and CDC's Congressional projects.

#### ***LEADERSHIP AND MANAGEMENT***

To enhance public health program, science, and practice effectiveness and achieve greater impact on America's health, CDC's Leadership and Management activity supports critical areas such as strategy and innovation, goals management, and health disparities. Components of this activity are described below.

#### ***CDC OFFICE OF THE DIRECTOR***

The CDC OD is comprised of the offices that manage and direct CDC's domestic and international health protection programs. The OD provides leadership, advises on strategy, and develops and evaluates the progress of goals and objectives related to disease prevention and control, including the correlation of these activities to health impact.

CDC is enhancing its efforts to accomplish greater health impact by developing and monitoring agency-wide goals, ensuring that CDC's goals focus on reducing and eliminating health disparities, and balancing health protection needs, science, and available resources to accomplish CDC's mission. To this end, CDC's executive leadership is provided with decision-making support through analytical assessments and strategy recommendations for achieving the greatest health impact for the public.

CDC's OD provides leadership, coordination, assessment, and evaluation for minority health initiatives; supports internal and external partnerships; and synthesizes, disseminates, and encourages use of scientific evidence identifying effective interventions to reduce health disparities. The OD also supports cooperative agreements with academic institutions and national nongovernmental organizations to conduct prevention research, program development, analysis, and evaluation to improve the health status of minorities and reduce health disparities. CDC funds key sectors to carry out student and professional research internship and fellowship opportunities that contribute to the improvement of diversity and cultural competency in public health.

CDC has expanded and enhanced activities related to scientific vision and leadership in science innovation, research, ethics, and science administration to ensure stability and commitment to long-term scientific investments to achieve its overarching health protection goals. To improve public health, the OD upholds scientific ideals and establishes an environment thriving with scientific excellence, innovation and integrity, learning and discovery, and the timely dissemination and translation of scientific information, innovations, and technology into practice. It facilitates developing approaches for long-term planning and evaluation of CDC's scientific enterprise and ensuring sustainability of scientific output; establishing and sustaining high-level national and global alliances and synergy; and ensuring development of public health policies using a scientific foundation. The OD facilitates research prioritization, planning, and evaluation across both intramural and extramural programs. The CDC research portfolio is designed for maximum impact on public health to achieve its desired ends.

CDC's science activities maintain the integrity and productivity of scientists by resolving controversial scientific issues, supporting training and information exchange, and providing direction on matters of scientific integrity. CDC ensures the protection of human subjects in public health research and participates in national and international initiatives in human subject protection. The CDC OD also manages CDC's intellectual property (e.g., patents, trademarks, copyrights) and promotes the transfer of new technology from CDC research to the private sector to facilitate and enhance the development of diagnostic products, vaccines, and products to improve occupational safety.

CDC's communications and issues management activities are coordinated and interconnected across the agency through the CDC OD. The OD collaborates with program, policy, and communications professionals to develop multi-faceted strategic responses to issues relevant to the whole agency or enterprise. The OD responds to urgent issues as they emerge and analyzes a range of information to proactively identify and propose responses to issues before they become urgent concerns. These activities ensure that CDC leadership has critical information with which to respond to urgent issues and ensure that enterprise staff and partners are aware of this information and the rationale that supports it.

The OD also incorporates the principal advisor to the CDC Director and manager of daily activities of the OD. These activities ensure that the multi-faceted and cross-cutting issues relating to efficiency and effectiveness of key decisions made by the CDC Director are reviewed and analyzed. The flow of information to the Director and CDC senior staff is also managed, as well as ensuring the CDC director is advised on key programmatic and policy issues.

CDC's activities in Washington D.C. allow for a presence to represent CDC leadership and programs to Congress, officials from HHS, and Washington, D.C.-based organizations that are existing or potential partners with CDC. This function provides service and products to these entities so that CDC can achieve its ultimate goal of improving health. In addition, CDC's Washington, D.C. office provides strategic representation for the agency with other federal agencies during management of crises and develops strategic partnerships with other federal agencies to accomplish administration and agency health goals in non-acute but high priority situations. Finally, the office advises agency leaders and scientists about developments in Washington, D.C. that bear on the accomplishment of administration and agency health goals.

Public health practice is a significant area of CDC's activities, ensuring coordination and synergy between scientific and practice activities throughout CDC. The principal means for achieving this level of coordination is to ensure practice-relevant standards, policies and legal tools.

#### *COORDINATING CENTERS, COORDINATING OFFICES, AND CENTER OFFICES OF THE DIRECTOR*

CDC's new structure includes several coordinating centers and offices, responsible for the coordination of thematic areas within and across operational centers. These responsibilities include identification of areas for collaboration; reduction of redundancies in business practices in concert with CDC's OD; incorporation of quality science and program to meet the agency's goals; leadership, decision-making, and management of operational units; and advising the Director on scientific, strategic, and programmatic issues. The coordinating centers work closely with the center ODs, which are responsible for developing scientific knowledge and quality program development; ensuring scientific credibility and integrity in all areas of expertise needed to address public health; accountability for addressing programmatic key performance indicators; serving as the foundation and core of CDC's science and services; and maintaining expertise needed to address public health emergencies.

#### **PUBLIC HEALTH WORKFORCE DEVELOPMENT**

CDC's workforce and career development activities are focused to achieve the following:

- Ensure a competent and sustainable workforce prepared to meet current and emerging health promotion and protection priorities.
- Ensure competent and sustainable leadership prepared to meet current and emerging health promotion and protection priorities.
- Ensure the use of best practices for workforce and career development sponsored by CDC.
- Promote an environment of continuous learning, which improves individuals' and the organization's performance.

To protect the public's health across the different life stages and to be prepared for outbreaks and public health emergencies, the public health workforce, at all levels and in sufficient numbers, must have the skills and competencies necessary to work effectively in a rapidly changing and complex environment. The knowledge and breadth of skills needed by the public health workforce, whether at CDC or in another setting, are growing and changing more rapidly than ever. To meet these needs, training programs must be continuous and adaptable, enabling the workforce to acquire and maintain the competencies needed to perform essential public health services and satisfy changes in mission, technology, and the content of work.

Toward this end, CDC will provide assistance with a broad range of training-related activities, including the establishment of learning standards, the development of training courses and materials, support and opportunities for continuing education, selection of the most effective training-delivery methods, implementation of training-related activities, and evaluation of training efforts. This assistance will be based on a scientific approach to training-related best practices and further enhanced by CDC's collective practical experience and expertise with developing and delivering training. In addition to serving as consultants regarding these training-related activities, CDC also will convene and work with experts to develop topic-specific training. Finally, CDC, in consultation with the agency's Excellence in Learning Council, develops, revises, administers, and evaluates the training policies governing Individual Learning Accounts at CDC. CDC is committed to providing all employees with flexible learning opportunities that are accessible through agency-funded Individual Learning Accounts and aligned with the agency's goals through Individual Development Plans.

To prepare for the future, CDC will implement targeted strategies for building a diverse, competent, and sustainable workforce, and will create a learning environment that enhances CDC's ability to attract and retain leaders who are prepared to meet current and emerging health protection needs.

### **RATIONALE FOR THE BUDGET**

The FY 2008 Budget of \$190,412,000 for PHIL reflects an increase of \$1,176,000 above the FY 2007 Continuing Resolution of \$189,236,000.

#### Pay Raise (+\$1.2 million)

The FY 2008 estimate includes a pay raise for PHIL, which allows CDC to continue supporting the administration and management costs associated with the programmatic activities across the agency. As CDC's science and program staff conduct critical activities and oversee the implementation of the nation's public health programs funded by CDC, increased funding to support pay for PHIL, a highly salary-based budget activity, is a necessary component of ensuring sustained support for CDC's public health programs.

### **PERFORMANCE ANALYSIS**

#### Current Activities

CDC continues to develop trained professional staff able to investigate health problems that affect the nation's population:

- Epidemic Intelligence Service (EIS) officers participate in domestic and international infectious disease investigations ranging from epidemics of meningococcal disease and Ebola hemorrhagic fever to West Nile Virus, monkeypox, Marburg virus, and Severe Acute Respiratory Syndrome (SARS). As their predecessors eradicated smallpox from the globe, today's officers are working to eliminate poliomyelitis and measles, as well as battling to prevent chronic diseases, violence, and injury. Approximately 70 percent of EIS graduates pursue public health careers.
- The Preventive Medicine Residency (PMR) 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 six to ten residents a year. CDC will increase recruiting efforts and expect this number to increase.
- The Public Health Prevention Service (PHPS) 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 (PEFP), tailored for quantitative policy analysts, economists and health services researchers, trains fellows 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 (PHIFP) trains professionals to translate and apply new and emerging information technologies to support the needs of public health programs. This two-year fellowship provides a unique and competency-based 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.
- The National Laboratory Training Network (NLTN) provides cost-effective, cutting edge, and basic training in the laboratory sciences. During FY 2006, the NLTN provided 255 courses and trained more than 27,000 public health and clinical laboratorians in areas such as biological and chemical terrorism preparedness, biosafety and biosecurity, molecular diagnostics, detection of antimicrobial resistance, and other areas of public health concern.

- The Excellence in Learning Council provides a cross-agency forum for enhancing agency-wide workforce and career development policies, programs, science and practices which assure a competent and sustainable workforce to address current and emerging public health needs.
- The Accredited Continuing Education Standards and Services program (ACESS) awards Continuing Medical Education (CME) to various continuing education activities at CDC, including satellite broadcasts, conferences, journal articles, MMWR RR, Web casts, and self-study courses. These activities are awarded and/or award Continuing Nursing Education (CNE), Continuing Education Units (CEU), Continuing Pharmacy Education (CPE), Continuing Health Education Credits (CHEC), and American Association of Veterinary State Boards Registry of Approved Continuing Education (AAVSB RACE).
- CDC provides access to and accredits training for health professionals, and provides an online registration and tracking system, called Training and Continuing Education Online.

**Significant Accomplishments**

- In FY 2006, headquarters EIS officers responded to 79 requests for assistance with epidemiologic field investigations from 29 U.S. states, 2 U.S. territories, and 15 other countries. In addition, field EIS officers assigned to state or local health departments conducted 374 epidemiologic field investigations in 47 U.S. states and 8 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 issues.
- In FY 2006, more than 125 trained professional staff were engaged in the response to Hurricanes Katrina and Rita: 95 EIS officers were deployed to the field and 13 to the Director's Emergency Operating Center (DEOC); 12 Prevention Specialists worked on relief efforts at the local level through their health agencies in eight states and the District of Columbia; five informatics fellows were deployed to help state/local agencies; and two PMR staff members were deployed (one to the DEOC and one to the National Center for Environmental Health to address mold and air pollution hazards).
- In FY 2006, PanFlu-specific training was developed for all EIS Officers and was added to the EIS curriculum in FY2007. This course prepares EIS Officers to assist in evaluating PanFlu surveillance systems, to train local health workers on PanFlu response, and to respond to domestic and international requests for assistance in the event of an actual outbreak
- Four Prevention Specialists and one Public Health Prevention Service staff member participated on STOP teams in India and Africa during the fourth quarter of FY 2005 and first quarter of FY 2006. Duties of assignees included the following: promoting, conducting and evaluating active surveillance for acute flaccid paralysis; conducting polio case investigations and follow-up; planning, implementing and evaluating National Immunization days and developing data management systems.
- During FY 2006, Prevention Effectiveness (PE) Fellows 1) calculated the cost-effectiveness of Indoor Residual Spraying (IRS) and Insecticide Treated nets (ITNs) for malaria control; 2) developed software that helps in deciding on the most cost effective treatment for gonorrhea in the presence of drug resistance; 3) developed software to calculate lost workdays due to next influenza pandemic; 4) estimated the outpatient visits for Influenza epidemic; 5) calculated the cost effectiveness of screening for congenital cytomegalovirus infections as an adjunct to newborn hearing screening; 6) summarized the results of the published cost-effectiveness studies on diabetes prevention and treatment; and 7) conducted a study of cost-effectiveness of aspirin usage in terms of reducing CVD events.
- In FY 2006, Public Health Informatics Fellows developed an electronic tool utilizing Personal Digital Assistants (PDA) equipped with global positioning systems for paperless data collection and an award-winning application for the visualization of disease reports that can be used anywhere in the world. Semantic Processing and Integration of Distributed Electronic Resources for Epidemiology (EpiSPIDER) was developed in collaboration with ProMED Mail and the National Library of Medicine Office of High Performance Computing and Communications. EpiSPIDER extracts information from reports of emerging infectious diseases (plant, animal and human) using natural language processing of text reports and plots those using Google Maps. In addition, Informatics Fellows assisted the Rhode Island Department of Health to integrate the outputs of five different surveillance systems, contributed to research efforts aimed at determining environmental factors that lead to physical inactivity and obesity, developing an information architecture for determining the impact of CDC research investments.
- In FY 2006, Preventive Medicine Residents were involved in activities around the country which led to: a revised structure for decision-making to guide the translation of evidence into immunization recommendations by the Immunization Practices Advisory Committee (ACIP); development of guidelines for a clinic to use a new procedure to test and treat *Wuchereria bancrofti*, Lymphatic Filariasis (LF), infections among people who are immigrants from Caribbean countries and who now reside in Florida; a new process for informing participants of the National Health and Nutrition Examination Survey (NHANES) about testing of drinking water in their homes for the disinfectant related

chemical group trihalomethanes; and improvements in the rates of eligible patients accepting flu vaccines when visiting Emergency Departments.

- The NLTN has begun a new series of teleconferences, Laboratory Learning Links (LLL), offering laboratorians the opportunity to learn about timely, pertinent public health topics such as antimicrobial resistance, influenza pandemic preparedness, molecular technology, and mycobacteriology detection.
- In FY 2006, three Agents of Bioterrorism: Train-the-Trainer Programs for the LRN Sentinel Laboratory courses were presented to participants in California, New Hampshire, and New Jersey by staff of the NLTN and the CDC. The online course "Bioterrorism Preparedness Training for LRN Sentinel Laboratories," a joint project with the Microbial Disease Lab of the California Department of Health Services, has added a sixth module on Burkholderia. More than 2,000 laboratorians from 49 states have accessed this course Over 6,250 participants received training in Pandemic Influenza Preparedness.
- During FY 2006, the ACESST program held a minimum of 36 Continuing Medical Education Review Board teleconferences, awarding Continuing Medical Education (CME) to 201 various continuing education activities, such as satellite broadcasts, conferences, journal articles, MMWR RR, Web casts, and self-study courses. These activities were awarded Continuing Nursing Education (CNE), Continuing Education Units (CEU), Continuing Pharmacy Education (CPE), Continuing Health Education Credits (CHEC), and American Association of Veterinary State Boards Registry of Approved Continuing Education (AAVSB RACE). During the same time period, approximately 64,077 health professionals participated in CDC-approved continuing education activities.
- The first-ever set of scientifically-derived competencies for applied epidemiologists were developed in collaboration with the Council of State and Territorial Epidemiologists. Other participants in the expert panel included representatives from the Association of State and Territorial Health Officials, the National Association of County and City Health Officials, and the Association of Schools of Public Health
- CDC maintained green status on strategic human capital standards in the President's Management Agenda during Fiscal Year 2006, and continued its efforts in workforce planning/analysis, succession planning, and diversity, in collaboration with CDC's Excellence in Learning Council.
- During FY 2006, CDC's Training and Continuing Education Online system tracked 32,239 health professionals (inside and outside CDC) who registered for and completed live training, and 21,269 health professionals who registered for and completed enduring courses.
- Between January 1, 2006, and August 18, 2006, 26,025 health professionals (inside and outside CDC) registered for and completed live training, as tracked by CDC's Training and Continuing Education Online system. During the same time period, 13,249 health professionals registered for and completed enduring courses, as tracked by the Training and Continuing Education Online system.

#### **OUTPUT TABLE**

<b>OUTPUT TABLE</b>	<b>FY 2006 ACTUAL</b>	<b>FY 2007 CR</b>	<b>FY 2008 BUDGET</b>	<b>FY 2008 +/- FY 2007</b>
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 <sup>1</sup>	0 <sup>2</sup>	2 <sup>2</sup>	2 <sup>2</sup>
Number of new Public Health Prevention Service Specialists annually	25	25	25	0
National, state and regional leadership development program graduates annually <sup>2</sup>	340	340	340	0
States participating in public health leadership and management training annually <sup>2</sup>	25 <sup>2</sup>	25	25	0

<sup>1</sup>These residents are usually funded through Association of Teachers of Preventive Medicine (ATPM). For FY 2006, CDC has one resident from Tulane at no cost to the agency.

<sup>2</sup>The ATPM mechanism for bringing on outside PMRs expired. If reinstated, it may be possible to bring on two outside PMRs for rotations in FY 2008.

NARRATIVE BY ACTIVITY  
PUBLIC HEALTH IMPROVEMENT AND LEADERSHIP

**FUNCTIONAL TABLE**

PUBLIC HEALTH IMPROVEMENT AND LEADERSHIP (DOLLARS IN THOUSANDS)	FY 2006 ACTUAL	FY 2007 CR	FY 2008 BUDGET	FY 2008 +/- FY 2007
Leadership and Management	\$161,592	\$161,703	\$162,879	\$1,176
World Trade Center	\$75,000	\$0	\$0	\$0
Director's Discretionary Fund	\$7,846	\$7,851	\$7,851	\$0
Public Health Workforce Development	\$19,668	\$19,682	\$19,682	\$0
Total	<b>\$264,106</b>	<b>\$189,236</b>	<b>\$190,412</b>	<b>\$1,176</b>

NARRATIVE BY ACTIVITY  
PREVENTIVE HEALTH AND HEALTH SERVICES BLOCK GRANT

## **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, Violent Crime Reduction Programs 40151 of P.L. 103-322

PREVENTIVE HEALTH AND HEALTH SERVICES BLOCK GRANT (DOLLARS IN THOUSANDS)	FY 2006 ACTUAL	FY 2007 CR	FY 2008 BUDGET	FY 2008 +/ FY 2007
BA	\$98,932	\$99,000	\$0	(\$99,000)

### **STATEMENT OF THE BUDGET**

The Preventive Health and Health Services Block Grant (PHHSBG) is eliminated in the FY 2008 Budget, a decrease of \$99,000,000 below the FY 2007 Continuing Resolution.

### **PROGRAM DESCRIPTION**

The PHHSBG has been a tractable source of funding, providing 61 grantees (50 states, the District of Columbia, two American Indian Tribes, and eight U.S. territories) the autonomy and flexibility to tailor prevention and health promotion programs to their particular needs. A portion of PHHSBG funding for prevention activities supports public health agencies in six states to improve health information and data systems.

### **RATIONALE FOR THE BUDGET**

PHHSBG is eliminated in the FY 2008 Budget, a decrease of \$99,000,000 below the FY 2007 Continuing Resolution. As CDC strives to improve efficiency and effectiveness, other existing resources will continue to be available for programs which have traditionally addressed similar public health issues.

### **PERFORMANCE ANALYSIS**

The PHHSBG provides funding support for primary prevention activities and health services that address more than 30 different health problems in local communities. Programs have targeted major issues such as cardiovascular disease, cancer, diabetes, tuberculosis, emergency medical services, injury and violence, infectious disease, environmental health, and sex offenses. In addition, the PHHSBG has supported activities such as clinical services, preventive screening, laboratory support, outbreak control, training, public education, and program evaluation.

### **OUTPUT TABLE**

OUTPUT TABLE	FY 2006 ACTUAL	FY 2007 CR	FY 2008 BUDGET	FY 2008 +/ FY 2007
Number of states, territories, American Indian Tribal organizations funded	61	61	0	0

## BUILDINGS AND FACILITIES

### AUTHORIZING LEGISLATION

PHSA §§ 304 (b)(4), 319D, 321(a)

BUILDINGS AND FACILITIES (DOLLARS IN THOUSANDS)	FY 2006 ACTUAL	FY 2007 CR	FY 2008 BUDGET	FY 2008 +/- FY 2007
BA	\$158,291	\$133,638	\$20,000	(\$113,638)

### STATEMENT OF THE BUDGET

The FY 2008 Budget of \$20,000,000 for Building and Facilities (B&F) reflects a decrease of \$113,638,000 below the FY 2007 Continuing Resolution of \$133,638,000. This investment will be used for Repairs and Improvements (R&I) of CDC's buildings. CDC will carry over necessary funding in FY 2007 to meet additional R&I needs in FY 2008.

### PROGRAM DESCRIPTION

With the charge of protecting the public health security of the nation, CDC is responsible for ensuring adequate facilities and equipment to carry out the agency's mission.

CDC is making dramatic progress in implementing its B&F Master Plan so all facilities, particularly laboratories, are safer for both workers and the community; taxpayer investments in these facilities are protected through effective maintenance and operations; and all CDC facilities are designed and operated responsibly to reduce consumption of resources (energy, water, and capital). Furthermore, strategic planning and asset management processes are identified and implemented to continually align CDC with HHS strategic goals and objectives as well as the President's Management Agenda. To meet these goals, CDC 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 as needed.

CDC's B&F program remains driven by a concern that the next public health emergency could overwhelm CDC's capacities to respond. Daily, CDC faces the potential need to respond to a terrorism event, an environmental disaster, or a public health threat such as a global influenza pandemic. With the opening of new facilities in 2005 through 2007, CDC's capabilities to respond to an emergency are dramatically increasing. In addition, when operational in 2009, the East Campus Laboratory Consolidation Project on the Roybal Campus will further enhance CDC's response capacity through the consolidation of Atlanta laboratories with better insect, animal, and environmental facilities to support research and response efforts.

In addition to CDC's government-owned Atlanta campuses, scientists and public health professionals occupy leased space in 21 different buildings at four separate locations. To improve 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.

### RATIONALE FOR THE BUDGET

The FY 2008 Budget of \$20,000,000 for B&F reflects a decrease of \$113,638,000 below the FY 2007 Continuing Resolution of \$133,638,000. This investment will be used for R&I of CDC's buildings. CDC will carry over necessary funding in FY 2007 to meet additional R&I needs in FY 2008.

### PERFORMANCE ANALYSIS

#### PART Results

Several ongoing actions to improve performance continue within the B&F program, including achieving 10 percent below market leased space. CDC used its market presence and sound negotiations to achieve below market lease rates. CDC also developed an agency wide program planning, tracking and performance measurement system, which collects information on the purpose, public health impact and overall performance of hundreds of ongoing projects throughout the agency. Ongoing evaluations and analysis of the efficiency and usability of this system continue as additional reporting and informatic needs arise.

### Current Activities

CDC is making substantial progress in replacing inadequate and energy inefficient buildings and facilities in Atlanta and non-Atlanta Campuses.

- CDC has initiated construction on an additional Atlanta Master Plan Project in FY 2005 (Environmental Health Facility).
- CDC began demolition and infrastructure activities in FY 2006 and initiated construction activities in early FY 2007 on an additional Atlanta Master Plan Project (East Campus Laboratory Consolidation Project).
- CDC has begun or completed pre-project planning for three Atlanta Master Plan projects (Epi Office Tower, Research Support Facilities – Buildings 107 and 108).
- CDC is constructing a laboratory facility in Fort Collins, Colorado, due for completion in FY 2007.
- CDC is underway with the environmental and preliminary site analysis for the consolidation of two antiquated NIOSH laboratories in Cincinnati, Ohio.

CDC continues to use innovative delivery approaches for capital projects to reduce procurement duration and bring critically-needed public health assets on-line quickly:

- 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.
- Design/Build (D/B) - In support of the HHS D/B initiative, CDC is aggressively implementing the use of this process to deliver major new building projects.
- 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 risk control for CDC.
- Sustainable Design – CDC’s B&F Program is committed to excellence and leadership in protecting the environment through compliance with environmental laws and regulations, specifying environmentally beneficial products and services and by promoting environments that are healthier, safer and more productive places to live and work. CDC measures its performance using the standards set forth by the Office of the Federal Environmental Executive (OFEE) Memorandum of Understanding (MOU) on “Federal Leadership in High Performance and Sustainable Buildings” (January, 2006) and the Leadership in Energy and Environmental Design (LEED™) Green Building Rating System of the U.S. Green Building Council (USGBC).

The OFEE MOU on “Federal Leadership in High Performance and Sustainable Buildings” goals and objectives are aimed at helping Federal agencies and organizations:

- Reduce the total ownership cost of facilities
- Improve energy efficiency and water conservation
- Provide safe, healthy, and productive built environments
- Promote sustainable environmental stewardship

USGBC LEED™ provides a framework for assessing building performance and meeting sustainability goals. LEED™ emphasizes strategies for sustainable site development, water savings, energy efficiency, materials selection and indoor environmental quality. LEED™ recognizes achievements and promotes expertise in green building through a comprehensive system offering project certification. CDC projects, encompassing buildings, infrastructure and landscaping, are encouraged to obtain basic LEED™ certification.

### Significant Accomplishments

- CDC has completed and occupied four Atlanta Master Plan Projects in FY 2005 (Emerging Infectious Disease Laboratory, Tom Harkin Global Communications Center, Arlen Specter Headquarters and Emergency Operations Center, Environmental Toxicology Laboratory).
- CMc - 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.

NARRATIVE BY ACTIVITY  
BUILDINGS AND FACILITIES

- D/B - CDC awarded a D/B contract for a 305,000 square foot Environmental Health Facility in FY 2005. Use of this process allows CDC to deliver projects with reduced risk, accelerated delivery, and net savings. As a result, CDC invested net savings in additional program and sustainable design and development features as encouraged by the Federal Facility Council.
- Accelerated Delivery – CDC has determined that projects under CMc and D/B methods reduce delivery time by one-third over other methods.
  - Atlanta Roybal Campus, Building 20: By re-siting the building, CDC has accelerated major elements of the project schedule by 14 months.
  - Atlanta Chamblee Campus, Building 106: By utilizing the D/B process, CDC has accelerated the total project schedule by 10 months.

Sustainable Design - CDC has three projects registered with the USGBC for LEED™ certification.

- Building 106 – Environmental Health Facility, currently under construction, includes:
  - minimization of negative impacts on the environment by restoring vegetation after construction through the use of native plant materials and absorption storm water management systems to increase biodiversity and improve surface water quality while minimizing maintenance costs;
  - minimization of heat island affects and increased energy efficiency by the use of vegetation shading and installation of a high-albedo roofing system;
  - incorporation of passive solar design including daylighting as the primary source of illumination supplemented by artificial lighting;
  - support of rapidly renewable materials to reduce impacts on resources and adopt protocols and procedures to minimize the waste stream including a contractor implemented waste management plan requiring recycling and/or salvage of at least 75 percent (by weight) of construction, demolition, and land clearing waste and specification of bio-based materials which typically have a ten-year or less growth cycle.
- Building 21, Arlen Specter Headquarters and Emergency Operations Center completed in FY 2005 received an USGBC LEED™ Silver certification. The facility is designed to improve the productivity and health of employees by providing an open environment that optimizes the use of natural daylight. Exterior sunshade fins control glare, and interior light shelves reflect light into the building to provide a balance between shading the building from heat gain and enabling more daylight to penetrate the interior. Energy initiatives aim to achieve energy reduction levels greater than 20 percent above standard codes (FEMP Focus, April 30, 2003)
- Building 110, Environmental Toxicology Laboratory is a design that consumes approximately 43 percent less energy than required by model energy codes incorporating energy-use zoning (lab areas served by a separate mechanical system; adjustable sash fume hoods with occupancy sensor; heat recovery using a run-around loop; variable speed pumping, and efficient humidification systems and controls). The building design also provides daylight views for 90 percent of the occupants and implements the use of energy efficient lighting with daylighting controls and occupancy sensors. Furthermore, the site design incorporates a rain garden to retain and absorb storm water after the water has been channeled through cisterns and rills to reduce velocity and includes native plant landscaping that minimizes the need for irrigation and fertilizer. (FEMP Focus, Summer 2004)

NARRATIVE BY ACTIVITY  
BUILDINGS AND FACILITIES

<b>CENTERS FOR DISEASE CONTROL AND PREVENTION</b> <b>BUILDINGS AND FACILITIES</b> <b>(DOLLARS IN MILLIONS)</b>				
<b>Facilities Project</b>	<b>Bldg No.</b>	<b>FY 2006 Actual</b>	<b>FY 2007 CR</b>	<b>FY 2008 Budget</b>
Atlanta-Based Facilities:				
- East Campus Laboratory Consolidation Project	23	\$120.0	\$50.0	---
DVBID Laboratory, Ft. Collins, CO	---	\$23.7	\$30.0	---
Cincinnati	---	----	\$14.2	----
IT-Related	---	\$7.1	----	----
National R&I Program (Incl. Planning)	----	\$7.5	\$39.4	\$20.0 <sup>1</sup>
<b>TOTAL, CDC B &amp; F Funding</b>		<b>\$158.3</b>	<b>\$133.6</b>	<b>\$20.0</b>

<sup>1</sup>A planned carryover balance of \$9.7 million will be retained in FY 2007 to bring FY 2008 R&I funding to levels consistent with prior year R&I amounts.

## BUSINESS SERVICES SUPPORT

### AUTHORIZING LEGISLATION

PHSA §§ 301, 304, 307, 310, 317, 317F, 319, 327, 361, 362, 368, 399F, 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 2006 ACTUAL	FY 2007 CR	FY 2008 BUDGET	FY 2008 +/- FY 2007
BA	\$317,576	\$317,781	\$319,877	\$2,096

### STATEMENT OF THE BUDGET

The FY 2008 Budget of \$319,877,000 for Business Services Support (BSS) reflects an increase of \$2,096,000 above the FY 2007 Continuing Resolution of \$317,781,000.

### PROGRAM DESCRIPTION

Over the past two years, CDC's business services structures and systems have been significantly enhanced to achieve greater effectiveness. CDC's budget structure was reorganized in FY 2005 to ensure greater transparency and accountability for programmatic dollars by identifying and separating costs related to business operations and processes into the BSS budget activity. The work conducted within this activity supports the premiere public health programs and science that make CDC America's lead public health agency and a respected resource for improving public health worldwide.

Guided by the 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 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.

To ensure business processes are effective and hold business services functions at the agency accountable for the services they provide, CDC devised specific key performance indicators (KPIs), including Web usage, Hiring Speed, Cycle Time and ServiceDesk Resolution Time, to encourage more visibility into various operational areas. Over the course of the past few years, CDC maximized use of those KPIs to realize performance within the Business Services Offices (BSOs) of the Office of the Chief Operating Officer (OCOO).

However, as the agency and HHS have continued to increase their focus on performance and accountability, CDC has begun revising the previously utilized set of KPIs to include not only a high level set reflecting agency-wide functions, but also a more detailed group within each BSO measuring each office's functional performance as it relates to the agency's overall efficiency. CDC expects to have a final set of high level, agency-wide KPIs ready in 2007. The more detailed KPIs are under development with a production date dependent on the detail and work required for each BSO.

The goal of this exercise is to expand business services KPIs to each coordinating center and national center, so that the business services functions within each programmatic area are measured as successfully as within the BSOs themselves. Once business services KPIs exist within the programmatic areas, the agency

Major activities within the OCOO include the following:

- Administrative Services and Program
- Alternative Dispute Resolution
- Buildings and Facilities
- Ethics
- Financial Management
- General Counsel
- Health and Safety
- Information Technology & Business Systems
- Procurement and Grants
- Security and Emergency Preparedness

should be able to realize increased efficiencies within key areas identified through outcome-oriented performance indicators.

The OCOO is responsible for tracking and reporting many business services functions outside of those reported using KPIs. The BSS budget activity is an extension of this system of accountability for business. Funds included in this budget activity include the OCOO as well as resources for areas such as rent, utilities, telecommunications, and security for CDC employees.

## **RATIONALE FOR THE BUDGET**

The FY 2008 Budget of \$319,877,000 for BSS reflects an increase of \$2,096,000 above the FY 2007 Continuing Resolution of \$317,781,000.

### **BSS Pay Raise (+\$2.1 million)**

BSS funding supports ongoing services maintained by CDC's business service units and expansion into new business areas that are critical to the success of the agency. The \$2.1 million pay raise increase requested in the FY 2008 estimate will allow CDC to meet increased personnel costs in this critical area.

## **PERFORMANCE ANALYSIS**

### **Current Activities**

CDC's business functions are carried out within the OCOO incorporating the following activities:

- Administering business services support for CDC and ensuring that CDC's business practices are efficient by applying proven public- and private-sector systems and practices.
- Leveraging information technology (IT) and information systems to support the agency's mission and to strive continuously to keep pace with the evolution of technology and advance public health in cost effective ways.
- Overseeing and carrying out PMA functions. (Please refer to the PMA section of this document for information about related accomplishments and activities.)
- Assuring 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.
- Assisting CDC managers in carrying out their health, safety, and environmental responsibilities by providing guidance, services, and oversight, including initiating and maintaining policy documents and manuals that implement this general policy.
- Utilizing KPIs to evaluate performance and effectiveness related to CDC's business functions, a snapshot of critical information about the most important aspects of business operations. KPIs are an essential performance management tool through which CDC proactively manages administrative performance and ensures efficient use of appropriated funds.

### **Significant Accomplishments**

- Reduced hiring time significantly through concurrent operation efficiencies within the Atlanta Human Resources Center (AHRC). In FY 2003, days-to-hire ("date recruitment action is received in AHRC" to "job offer date") averaged 92 workdays. At the end of FY 2005, the days-to-hire average was 73 workdays with the FY 2006 goal set at 58 workdays (all averages exclude announcement open periods). These gains have occurred despite an almost 50 percent increase in staffing workload within AHRC. In addition, CDC exceeds the Office of Personnel Management's (OPM) hiring goal of 45 workdays from announcement closed to job offer (i.e., in 42 workdays).
- Continued to lead a multi-year initiative to shift more staff to frontline public health programs, thereby increasing CDC's positive impact on America's health and well-being. For example, AHRC worked with the OCOO to develop a FY 2005 Voluntary Separation Incentive Payment (VSIP) plan (approved by OPM) to help CDC reduce the number of mission-support staff. This plan was extremely successful. For example, by the end of FY 2005, more than 300 individuals in mission-support positions elected regular or early-retirement with a VSIP. Furthermore, at least half of these FTEs were redirected to mission-direct positions.
- Enabled CDC's programs to implement health-related programs and initiatives through the acquisition and assistance activities of the Procurement and Grants Office (PGO). PGO also protects the public trust by ensuring the integrity and effectiveness of financial assistance and acquisition processes. PGO provides management of all CDC acquisition and assistance awards. PGO is also implementing process improvement measures and KPIs to decrease the amount of time taken to award contracts and grants, thereby increasing the speed with which public health interventions can be put into place.
- Achieved 126 days to institute a new contract against an aggressive target of 165 days in FY 2005, which is much lower than the FY 2003 baseline of 217. CDC focused on ensuring process improvements established in FY 2004 were sustainable while measuring against the aggressive target set during FY 2005. Also, new procedures are being developed in FY 2006 to improve efficiency, which may slightly increase cycle time over FY 2005 levels due to the implementation complexities.

NARRATIVE BY ACTIVITY  
BUSINESS SERVICES SUPPORT

- Consolidated all common CDC IT infrastructure services to achieve higher performance at lower cost through the Information Technology Services Office (ITSO). This consolidation reduced operating costs by 30 percent and staff by 29 percent, while increasing service offerings, expanding service hours and locations, improving service levels, and reaching a "best-in-class" customer satisfaction result.
- Experienced over 30 percent growth per year in visits to CDC's Web site, compounded over the last five years and now exceeding 13 million visitors per month on average. Visits to the CDC Web site reflect the quality, timeliness, trust, and value of CDC's information to the public. During public health emergencies, visits to the site spike dramatically as the public seeks emergency-related information.

## TERRORISM

### AUTHORIZING LEGISLATION

PHSA §§ 301, 307, 311, 317, 319, 319A, 319C, 319D, 319F, 319F(2) 319G, 361-368 (42 U.S.C. 262 note), 2801-2811. Public Health Security and Bioterrorism Preparedness and Response Act of 2002

TERRORISM (DOLLARS IN THOUSANDS)	FY 2006 ACTUAL	FY 2007 CR	FY 2008 BUDGET	FY 2008 +/- FY 2007
BA	\$1,576,173	\$1,543,947	\$1,504,375	(\$39,572)
Department of Defense	\$55,000	\$0	\$0	\$0
<b>Total</b>	<b>\$1,631,173</b>	<b>\$1,543,947</b>	<b>\$1,504,375</b>	<b>(\$39,572)</b>

### STATEMENT OF THE BUDGET

The FY 2008 Budget of \$1,504,375,000 for Terrorism reflects a decrease of \$39,572,000 below the FY 2007 Continuing Resolution of \$1,543,947,000.

### PROGRAM DESCRIPTION

The health and security of the United States depends on our preparedness against terrorism, bioterrorism and natural public health emergencies. Helping lead this effort is the Department of Health and Human Services' Centers for Disease Control and Prevention (CDC) Coordinating Office for Terrorism Preparedness and Emergency Response (COTPER). The national focus on bioterrorism preparedness is having a positive effect on state and local public health systems. Preparedness funds enable communities to develop the building blocks needed to respond to varied disaster scenarios, including chemical, biological, radiological, and nuclear (CBRN) events. Community leaders have stated that this infrastructure has multiple uses that benefit broader public health responsibilities, especially those related to infectious disease control. CDC has received more than \$8 billion since 2001, and will continue its commitment to building preparedness and response capacities across the nation and to enhance the capacity of the federal, state, and local public health systems to address all potential hazards.

CDC has established a framework to execute and implement the agency's overarching preparedness goals and the HHS Strategic Plan to Combat Bioterrorism and Other Public Health Emergencies. Combined, these goals lay a foundation for overcoming the challenges that public health faces against terrorism and will continue to be reshaped as necessary to meet evolving needs and priorities. Directed by the CDC Health Protection Goal, "People in all communities will be protected from infectious, occupational, environmental, and terrorist threats," CDC has identified the following six components necessary to an effective preparedness framework: Prevention, Detection and Reporting, Investigation, Control, Recovery and Improvement. This framework is designed to be outcome and performance driven while providing a structure for the execution of the agency's strategic goals and to create a pathway for smooth implementation of a comprehensive preparedness and emergency response program.

To support and help track these efforts the following nine preparedness goals have been established to help measure and gauge performance.

#### **Pre-Event**

##### *Prevention*

1. **Increase the use and development of interventions known to prevent human illness from chemical, biological, radiological agents and naturally occurring health threats.** This goal is centered on increasing CDC's and its partners' ability to prevent public health emergencies. It is designed to encourage investments and application of known interventions, such as the use of vaccines and personal protective equipment, but also provides room for the innovation of new and effective interventions based on scientific discovery.

#### **Event**

##### *Detection and Reporting*

2. **Decrease the time needed to classify health events as terrorism or naturally occurring in partnership with other agencies.** Here CDC encourages the use of modern tools to enhance surveillance, epidemiology and laboratory capacity, as well as the integration of national security data and resources with health information from around the globe. The public health community is in a unique position to use scientific measures to detect and report unusual health events quickly by using systems like PulseNet and

integrating state and local health departments into the Public Health Information Network (PHIN). The BioSense project is a prototype for such an effort through its innovative surveillance of different clinical and health data streams and its ability to analyze them to help spot potential outbreaks or bioterrorist attacks effectively and efficiently.

3. **Decrease the time needed to detect and report chemical, biological, radiological agents in tissue, food, or environmental samples that cause threats to the public's health.** This goal demonstrates CDC's commitment to continue supporting state and local public health departments and laboratories in determining the cause and extent of public health emergencies.
4. **Improve the timeliness and accuracy of communications regarding threats to the public's health.** In order to accomplish this goal CDC is combining advances in information technology with the long standing relationship CDC has with health care providers, to create a continuum of efforts from the individual provider to the community and the nation.

*Investigation*

5. **Decrease the time to identify causes, risk factors, and appropriate interventions for those affected by threats to the public's health.** This goal drives the public health system's ability to conduct investigations to determine the cause and breadth of public health emergencies. Accomplishments are achieved using methods including "disease detection" work public health epidemiologists are known for, as well as the speed with which messages can reach the public regarding the issue and ways to protect oneself from the threat. CDC and its public health partners are putting into place plans and systems designed to control the damage of a catastrophic event. By increasing the number of quarantine stations and expanding their capacity through science, partnership, and preparedness, the U.S. quarantine network will be better equipped to play an active role in worldwide biosurveillance, coordinate nationwide response to global microbial threats of public health significance that have the potential to cross U.S. borders, and protect the U.S. public from communicable disease threats.

*Control*

6. **Decrease the time needed to provide countermeasures and health guidance to those affected by threats to the public's health.** This goal allows for opportunities to create structures to provide immediate information and medication, if needed, to the masses. It also provides planning and training for localities to quickly receive and distribute the Strategic National Stockpile (SNS), a national repository of life saving pharmaceuticals, medical material and equipment. CDC supports programs, such as the Cities Readiness Initiative (CRI), to enhance and test capabilities related to receipt and distribution of the SNS in large metropolitan areas.

The final components, stated in three goals, relate to assuring that state and local health departments in conjunction with federal teams can quickly restore services, learn, and improve from each event.

**Post Event**

*Recover*

7. **Decrease the time needed to restore health services and environmental safety to pre-event levels.** This goal sets the stage for rapid re-establishment of vital public health services for non-emergency conditions. CDC's close partnerships with state and local health departments will allow for materials and personnel to be quickly dispatched and integrated, thereby decreasing the time that vital services are adversely affected.
8. **Increase the long-term follow-up provided to those affected by threats to the public's health.** Here CDC allows for additional scientific knowledge, health care, and data collection to support continuous improvements in the delivery of public health interventions and the prevention of morbidity and mortality during subsequent events. The knowledge gained from these studies will provide useful information for future responses.

*Improve*

9. **Decrease the time needed to implement recommendations from after-action reports following threats to the public's health.** This final goal includes requirements for robust tracking of lessons learned and implementation of corrective actions to support response or enhance response support in the future. This constant re-evaluation is designed to ensure maximum efficiency and the best possible response to those affected by a CBRN or other public health emergency.

Investments to strengthen early detection, response, and containment of biological public health threats are being implemented through several key initiatives. Since FY 2004, Project BioShield provides for the purchase of needed vaccines and antibiotics under the administration of the Strategic National Stockpile (SNS). Second is the Biosurveillance Initiative which is a multi-agency program to improve the early detection and containment of potential health threats to the U.S. population. CDC's portion of this initiative includes the BioSense project, through which CDC is assuring that information technology tools are being leveraged to provide data from multiple disparate data sources into a fully functioning, real-time surveillance system. Utilizing these tools, federal, state, and local health officials will have access to real-time data that could potentially be the first sign of a public health emergency or even a bioterrorist attack.

CDC is also focusing on increasing public health security at the borders through the creation of additional quarantine stations at airports and other major sites of entry into the U.S. With only 8 stations in FY 2004, these critical security areas were able to expand to 18 stations by the end of FY 2005 and will reach up to 25 stations by the end of FY 2008. Finally, CDC is investing Biosurveillance resources to increase real-time lab reporting. This program is helping to increase information systems supporting laboratories across the nation. These systems are responding to real-time test requests and providing results to CDC that are included among data points used to monitor the public's health.

Over the past six years, CDC has invested resources and time to assure that preparations and measures are in place to provide a comprehensive and effective public health response to a bioterrorist incident or an infectious disease emergency, like SARS, Avian Influenza or an influenza pandemic. The newly established framework is a result of lessons learned from CDC responders and state and local partners, from exercises conducted at the federal, state, and local levels and from the dedicated efforts of scientists and leaders across the country responding to the heightened attention on bioterrorism preparedness.

CDC is involved in a multitude of preparedness efforts for a potential influenza pandemic. The goal of CDC is to suppress the first outbreak before it spreads. CDC is working with HHS to conduct pandemic preparedness summits with public health emergency management and response leaders in each state; CDC is developing a Pandemic Influenza Operational Plan and a functional Incident Management System that will work for pandemic influenza and other hazards; and CDC's SNS is working to ensure that critical items are in place to save lives and prevent illness during a pandemic event. These activities highlight some of CDC's efforts and initiatives towards influenza pandemic preparedness.

Investments are yielding dividends with many public health officials who are crediting CDC's work in areas such as increasing visibility of public health issues allowing for better community engagement and encouraging more people to look for jobs in public health fields. Close communication and coordination across all sectors of the public health system now exists. In the past, differences in organizational cultures, terminology and approaches to emergency response have been barriers to effective interagency collaboration, but the imperatives of public health preparedness has required that these agencies understand each other's roles and capabilities in the case of a disaster. As a result, stronger relationships have developed between public health officials and their counterparts in medical care and public safety. Relationships among federal, state, and local agencies have improved. In addition to the increased communication between CDC, state, and local agencies, interactions have increased with other federal agencies, such as the Federal Bureau of Investigation and the Department of Homeland Security. A number of states have established regions through which local organizations work together. The federal, state and local partners have committed to creating a flexible system of exploration, vision and improvement through coordinated exercises and thorough evaluation in order to create a more robust public health system.

After a catastrophic natural disaster or weapons of mass destruction event patients, seeking treatment will likely overwhelm local and regional medical resources with a surge in both those who are injured and the worried well. HHS serves as the lead federal agency in coordinating mass casualty medical response and recovery efforts in support of the National Response Plan and Homeland Security Presidential Directive 10. In this capacity, HHS is expanding federal resources to augment existing regional, state, and local hospital resources. For example, the SNS is developing Federal Medical Stations (FMS) to increase bed capacity and aid recovery efforts at the state and local levels. The SNS will store and deliver FMS assets to an event site. FMS' modular design facilitates rapid transit by land or air and can be set up in close proximity to hospitals and inside large structures (e.g., convention centers, sports arenas). These transportable assets are capable of providing a continuum of health care services from basic nursing to specialized care for pediatric, adult, and elderly patients; FMS also allows for the quarantine of patients. Capacity for FMS is between 50 to 250 beds depending on the magnitude of the incident and existing health care resources. The FMS includes administrative, treatment, infirmary, and pharmacy modules and is staffed around the clock with federal, state, and local personnel including nurse, physician, pharmacy, and support services skill-sets.

The FY 2008 budget for terrorism will strengthen CDC's ability to continue the investment in preparedness and response efforts, expanding terrorism preparedness for chemical, biological, radiological and mass trauma events and assessing the effects of these investments on public health preparedness capacities.

## **RATIONALE FOR THE BUDGET**

The FY 2008 Budget of \$1,504,375,000 for Terrorism reflects a decrease of \$39,572,000 below the FY 2007 Continuing Resolution of \$1,543,947,000.

### **Strategic National Stockpile (SNS) (+\$89.9 million)**

The SNS permits CDC to respond to mass trauma events by delivering medical supplies to any point in the U.S. within 12 hours. As new threats emerge and medical countermeasures are developed, additional supplies of pharmaceuticals and medical materials will be acquired for the SNS. To ensure that the SNS expands and maintains necessary readiness levels, increased funds are required.

Priority for all funding used for acquisitions will be toward the purchase of additional regimens of anthrax intravenous antibiotics and prophylaxis to treat and protect persons exposed or presumed exposed in the event of an anthrax attack. In order to provide projected coverage for treatment and prophylaxis, the following will be purchased for treatment: ciprofloxacin (approximately 800,000 regimens), rifampin (approximately 292,000 regimens) clindamycin (approximately 363,000 regimens), and penicillin G (approximately 285,000 regimens). To increase prophylaxis capabilities, approximately eight million regimens of doxycycline and two million regimens of ciprofloxacin will be purchased.

### **Quarantine (+\$10.0 million)**

Increased funding of \$10.0 million in FY 2008 will support up to 25 stations in FY 2008. CDC focuses on increasing border security through the creation of additional quarantine stations at airports and other major sites of entry into the U.S. With only eight stations in FY 2004, these critical security areas were able to expand to 18 stations by the end of FY 2005 and will reach up to 25 stations by the end of FY 2008.

### **Anthrax (-\$13.9 million)**

In FY 2008, CDC proposes to eliminate funding for the anthrax research study. With the completion of the anthrax vaccine clinical trial interim safety analysis, CDC has presented the results to key stakeholders and submitted the final report detailing all findings from the safety analysis to the Food and Drug Administration. This brings the long running anthrax study near its conclusion. The information gleaned over the course of this study will not be compromised due to the cessation in funding, and the expected benefits will have been gained by the time of the project's completion.

### **Upgrading State and Local Capacity (-\$125.4 million)**

CDC's funding for Upgrade State and Local Capacity has contributed significantly to strengthening preparedness for a response to bioterrorism, outbreaks of infectious disease, and other public health threats and emergencies. While recognizing competing priorities, CDC proposes a reduction of \$125.4 million to Upgrading State and Local Capacity. During FY 2006, states have received \$600 million in pandemic influenza funding for activities similar to those funded through the Upgrading State and Local Capacity Program. CDC will focus funding to state and local governments to continue to upgrade capacity.

### **BioSense (-\$0.2 million)**

With the funds proposed in FY 2008 for BioSense, CDC will focus on communicable infectious disease threats and preserving BioSense's software development and data analysis capability. In an effort to improve program performance, CDC proposes to realign the effort and narrow the scope of BioSense to public health emergency preparedness. To do so, CDC will limit the number of participating cities and restrict program expansion to include only the most populous U.S. cities and improve the system's surveillance for seasonal influenza and conduct exercises with this system related to a bioterrorism event.

## **PERFORMANCE ANALYSIS**

### **PART Results**

Following its PART review in 2003, the State and Local Preparedness Grants program developed critical tasks and performance targets as goals for the Public Health Emergency Preparedness Cooperative Agreement Program. These goals were integrated into grant guidance for FY 2005 and are directly tied to state partner activities. All ongoing cooperative agreement activities will continue to be aligned with the overarching CDC health protection goals. Technical assistance will be provided to partners as necessary. Independent evaluations will be conducted to determine performance of partner activities and to provide recommendations for ongoing follow-up.

The SNS program (2005) is working to analyze cost and performance through providing recommendations to CDC regarding process flows and proposed changes. Through resource allocation analyses, the program established a framework for enhancing the scientific evidence based approach for acquisition related decisions. The framework enabled the assignment of Federal Medical Station (FMS) material assets to CDC. These assets will provide an enhancement to the long range planning process, providing defined deliverables, capability/performance characteristics and schedule goals in an ongoing tracking and reporting process. The program is also continuing to develop performance tracking and measurement systems in accordance with CDC's budgeting and performance software database, as is the State and Local Preparedness Grants program.

Additionally, the Biosurveillance and Upgrading CDC Capacity programs (2006) are continuing to develop milestones and targets to align with the programmatic outcome goals and measures. Through the use of budget and performance integration tools and software, the programs will be able to demonstrate adequate progress in achieving annual and long-term performance targets and goals. Independent evaluations of all Biosurveillance and Capacity programs are currently being scheduled to ensure connectivity between, and completion of, upcoming targets and results.

## ***PREVENT***

CDC provides resources to address the science and application of interventions to decrease the morbidity and mortality resulting from threats to the public's health. CDC encourages investments in and the application of known interventions, such as the use of vaccines and personal protective equipment to provide defense against diseases, but also encourages innovation of new and effective interventions based on scientific discovery.

### **GOAL 1: INCREASE THE USE AND DEVELOPMENT OF INTERVENTIONS KNOWN TO PREVENT HUMAN ILLNESS FROM CHEMICAL, BIOLOGICAL, RADIOLOGICAL AGENTS AND NATURALLY OCCURRING HEALTH THREATS.**

#### Current Activities

- Anthrax Vaccination Program: provides anthrax vaccinations to laboratorians across the nation who work with *Bacillus anthracis* in public health laboratories.
- American Red Cross Project: develops and disseminates educational messages that provide self-instruction to citizens preparing for public health emergencies.
- Standards Development: further refine standards for respirators used to protect first responders and other workers from chemical, biological, radiological or nuclear threats.
- The Centers for Public Health Preparedness (CPHP) program: a network of academic-based preparedness programs in 27 accredited schools of public health, one university, and one health center. The CPHP provides preparedness education and other requested services to health agencies in all 50 states.
- The Advanced Practice Centers (APC) Program: assists Local Public Health Departments (LHD) with responding to Public Health emergencies. CDC currently supports eight APCs to implement a network of innovative LHDs who will target activities and efforts that improve community preparedness and response, analyze lessons learned from all APCs and disseminate these lessons and best practices to the broader national public health community.

#### Significant Accomplishments

- CDC completed the anthrax vaccine clinical trial interim safety analysis, presented the results to key stakeholders, and submitted the final report detailing all findings from the safety analysis to the FDA.
- CDC developed and issued performance standards for four classes of respirators for use in CBRN environments, including one for self-contained breathing apparatus (SCBA) respirators and one for full-face piece air-purifying (FFAP) respirators for occupational use by emergency responders.
- CDC developed comprehensive response planning guidance for Autonomous Detection Systems. Detection systems were installed in over 250 U.S. postal facilities across the nation to monitor for hazardous biological agents.
- The Centers for Public Health Preparedness (CPHP) developed 443 public health preparedness education and training activities, as well as 795 public health preparedness resources, which are available in the CPHP Internet-based Resource Center.

- During the Hurricane Katrina response, CDC established an agency-wide emergency communications network, involving multiple centers. The communication response provided clear evidence that this network is effective in ensuring that CDC is able to respond with one voice in emergent situations.
- CDC's Anthrax Vaccine Research program is firmly established as the Gold Standard for anthrax vaccine evaluation as witnessed through formal requests by NIAID, NIH, Battelle Memorial Institute, and the UK HPA to adopt and manipulate CDC computer software for analysis of anthrax lethal toxin neutralization assays.
- CDC's Geographic Research, Analysis, & Services Program (GRASP) for Planning During Emergency Response project has automated its project management processes and now has standard procedures in place for tracking project time and handling project files in regard to Rapid Response and Emergency Preparedness Support (RREPS), Geospatial Informatics, Systems, & Applications (GISA), and Geospatial Applied Research, Training, and Support (GEOSTAR).

## ***DETECT AND REPORT***

Detection activities center on CDC's commitment to continue providing resources to state and local public health departments and laboratories to determine the cause and extent of public health emergencies. CDC believes that all possible measures should be taken to detect an event so that intervention can begin as early as possible to minimize morbidity and mortality.

### **GOAL 2 – DECREASE THE TIME NEEDED TO CLASSIFY HEALTH EVENTS AS TERRORISM OR NATURALLY OCCURRING IN PARTNERSHIP WITH OTHER AGENCIES.**

#### **Current Activities**

- The Select Agent and Toxins Program further builds the nation's capacity to monitor and regulate entities that possess, use, and transfer select agents and toxins to ensure their safety and security.
- The PulseNet surveillance system for *y. pestis* and *f. tularensis* provides molecular subtyping of infectious organisms to allow public health officials to establish links between cases. Additionally, for Category A agents, PulseNet can provide critical insight into whether or not outbreaks are naturally occurring or result of intentional release.
- CDC's BioIntelligence Center monitors incoming data from data providers, such as laboratory test orders and results from a national clinical laboratory performing over 300,000 tests daily and other BioSense data feeds.
- To further expand and improve national laboratory response to an event, the Integrated Consortium of Laboratory Networks (ICLN) was established in FY 2005 to promote collaboration, communication, and technical acuity throughout the government's overall response strategy. This group is led by the Department of Homeland Security and includes representatives from various federal agencies. Together, all of these lab networks cover the diverse biological, chemical, radiological and nuclear materials that may be detected in clinical, environmental, or food samples.
- A strategy to develop a toolkit for the public health laboratory community to address recruitment, retention, and succession planning is being conducted by three state laboratory directors and one environmental health expert. This toolkit will assist with the efforts of the National Center for Public Health Laboratory Leadership (NCPHLL) to strengthen the laboratory leadership community which will positively impact CDC's Health Protection Goal of decreasing the time to identify causes, risk factors, and appropriate interventions for those affected by threats to the public's health.
- In addition to Veteran's Administration (VA) and Department of Defense (DoD) health data, in FY 2005, BioSense began receiving real-time clinical data from 45 private hospitals in 10 large metropolitan areas in order to better provide early event detection and community health situational awareness capabilities for federal, state, and local public health. By the end of FY 2006, BioSense began receiving data from at least 32 cities and over 150 hospitals.

#### **Significant Accomplishments**

- Through CDC's Select Agent and Toxins Program, CDC initiated the investigation of all thefts, losses, and releases of select agents or toxins within five days of receipt of report. Additionally, the program developed and tested a national Select Agent database and system that will provide a single source for registration, transfer, amendments, inspection data, and other required information.

- Since the implementation of BioSense, the program has received daily data feeds from an initial set of data providers, and to date has received and processed over 416 million records from the DoD and VA. The BioSense application is 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.

**GOAL 3: DECREASE THE TIME NEEDED TO DETECT AND REPORT CHEMICAL, BIOLOGICAL, RADIOLOGICAL AGENTS IN TISSUE, FOOD OR ENVIRONMENTAL SAMPLES THAT CAUSE THREATS TO THE PUBLIC'S HEALTH.**

**Current Activities**

- CDC's Environmental Health Laboratory is developing new methods and substantially improving current methods for quantitatively measuring the levels of 20 chemical agents or their metabolites in clinical samples to be used to identify people who have been exposed and their extent of exposure. Additionally, CDC will maintain and expand its proficiency testing and technology transfer activities to the 62 state and territorial laboratories in order to enhance their capacity to assess exposure to chemical agents using measurement in blood and urine.
- The Specimen Tracking and Results Reporting System (STARRS) aims to create an environment for sample tracking and results aggregation to enable the sharing of laboratory information across CDC laboratories.
- The LRN Real time Laboratory Information Exchange will enable integration of laboratory test results from LRN reference labs, sentinel labs, and CDC.

**Significant Accomplishments**

- The National LRN meeting occurred in May 2005. The purpose of the meeting was to provide LRN laboratories with an update on LRN growth and expansion, select agent and other regulatory issues, environmental testing and triage guidelines, current and emerging technologies, proficiency testing for biological and chemical laboratories, and the upcoming CDC Preparedness Cooperative Agreement announcement. The next meeting is being planned for 2007.
- CDC increased the number of LRN labs from 91 in FY 2001 to 152 in FY 2006. This number includes food and veterinary labs, allowing for greater ability to detect threat agents in the nation. These labs are located in all 50 states and the LRN even boasts several installations abroad. Of the labs funded through the FY 2006 cooperative agreement, 100 percent can confirm anthrax, tularemia, and plague and more than 90 percent can confirm melioidosis, ricin toxin, staphylococcal enterotoxins, SARS virus, non-variola orthopox, and influenza A/H5. CDC has trained more than 9,000 clinical laboratorians to play a role in the detection, diagnostics and reporting of public health emergencies.
- CDC's LRN was one of 18 finalists for the 2005 Innovations in American Government (IAG) award, sponsored by Harvard University's Ash Institute and the John F. Kennedy School of Government. The LRN was selected from more than 1,000 applicants based on the program's novelty, effectiveness, significance in national terrorism preparedness and the transferability of its concept.
- CDC conducted an incident response exercise in December 2005 involving analysis of unknown agents in clinical samples. CDC conducts at least two incident response exercises a year that assess its ability to apply the Rapid Toxic Screen (RTS) in emergency situations. The exercise included deployment of the response team, transport of samples, allocating and sample preparation, specimen analysis, results determination, quality control, and data reporting.
- CDC has conducted two courses on the topic of Agents of Bioterrorism: Train-the-Trainer for the LRN Sentinel Laboratory. The goal of these courses is to assist with the development of a public and clinical laboratory workforce capable of responding to terrorism threats.
- Two real-time subtyping assays for the clinically significant *F. tularensis* subspecies, tularensis and holarctica, were developed, evaluated and transferred to the LRN for distribution to both LRN and BioWatch laboratories. The development of a test for determining these different subspecies is highly useful for interpretation of *F. tularensis*-positive BioWatch signals and distinguishing natural phenomena from a potential terrorist event.
- LRN Assay for H5N1 Asian lineage influenza has been developed and deployed to all states with a successful FDA 510(k) approval.

- Disinfection studies of potable water with concentrations of chlorine and monochloramine have established contact values that will allow drinking water plant operators to optimize their disinfection strategies if a system has been contaminated with *Bacillus anthracis*, *Yersinia pestis*, *Francisella tularensis*, *Brucella* spp, *Burkholderia pseudomallei*, or *B. mallei*.
- Completed development work on a new technique for simultaneous capture and recovery of viral, bacterial, and parasitic biothreat agents in large-volume drinking water samples. Research performed in FY 2006 indicated that this new technique performs as well or better than established methods designed for specific capture of viruses or parasites.

**GOAL 4: IMPROVE THE TIMELINESS AND ACCURACY OF COMMUNICATIONS REGARDING THREATS TO THE PUBLIC'S HEALTH**

**Current Activities**

- The Smallpox – Rash Illness Surveillance projects increase national capacity for evaluation and response to a suspected smallpox case, decrease the time in detecting a smallpox case, and improve the timeliness of gathering information on a potential smallpox case.
- Through adoption of PHIN standards applied at state and local health departments, information may be exchanged through alerting, laboratory, directory, and other systems through support of CDC Enterprise Communication Technology Platform.
- In support of the DHHS Secretary's charge to establish a national and integrated system for public health in support of terrorism response and prevention, CDC employed the Technical Assistance Group (TAG) to provide expertise, resources, roadmaps, and independent validation to help public health organizations improve their information technology and prepare for and respond to public health emergencies.

**Significant Accomplishments**

- CDC continues to work to improve public health's surveillance of chemical exposures and other potential health hazards by developing the infrastructure necessary to systematically collect, analyze, interpret, and disseminate data related to health events. CDC improved the ability of poison control centers to respond to public health emergencies related to chemicals or toxins in the environment by detecting a problem or an incident immediately and effectively.
- CDC participated in 12 group site visits and provided an IT assessment site visit report, engaged 43 partners with group site visits and conference calls to facilitate PHIN certification, and cross trained staff for PHIN certification.
- CDC has been working to increase the number of public health officials capable of being alerted across jurisdictional boundaries on the basis of their public health role and the number of affiliate personnel and organizations (e.g., physicians, hospitals nurses, labs, clinics) registered in PHIN directories and capable of being alerted across jurisdictional boundaries. This effort is to increase the ability of the public health community to collaborate and respond to a public health emergency.

**INVESTIGATE**

This goal provides the framework for the public health system's ability to conduct investigations to determine the cause and breadth of public health emergencies. Accomplishments are achieved using methods including "disease detection" work public health epidemiologists are known for, as well as the speed with which messages can reach the public regarding the issue and ways to protect oneself from the threat. CDC and its public health partners are putting into place plans and systems designed to control the damage of a catastrophic event.

**GOAL 5: DECREASE THE TIME TO IDENTIFY CAUSES, RISK FACTORS, AND APPROPRIATE INTERVENTIONS FOR THOSE AFFECTED BY THREATS TO THE PUBLIC'S HEALTH**

**Current Activities**

- Biosurveillance: Currently, CDC seeks to fully staff between 20 and 25 quarantine stations in FY 2007. These quarantine stations will be staffed with multidisciplinary teams of quarantine medical officers, public health advisors, epidemiologists, and information technicians who respond to public health emergencies at U.S. ports of entry, allowing communication of disease intelligence information to domestic and international partners as well as expeditious movement of clinical and research materials through ports of entry. CDC is conducting a training needs assessment for partner agencies that are nontraditional public health partners who play an important role

in supporting the mission of CDC at ports of entry to determine their respective public health training needs and resources.

- In FY 2006, CDC took a strategic leadership role in developing community mitigation and international border strategies to be used in the event of pandemic influenza. In this role, CDC continues to develop the scientific base for non-pharmaceutical interventions (NPI) and offer guidance to federal, state, and local agencies to effectively prepare for and mitigate the pandemic strain of influenza.
- The creation and use of the Epidemic Information Exchange (Epi-X) enables CDC to provide secure, moderated communications and notification services.
- The Career Epidemiology Field Officer (CEFO) program provides skilled epidemiologists to state and local health departments, continuing support of its mission to enhance public health preparedness in state and local health departments.
- The Epidemiologic Intelligence Service (EIS) provides a competent epidemiological science workforce to the Public Health Service, CDC and state and local partners.
- CDC provides skilled staff, guidance and technical assistance to state and local health departments when planning for and responding to public health emergencies.

#### Significant Accomplishments

- The CEFO program prepared a cadre of subject matter experts in applied epidemiology who are adequately trained and ready to provide tailored services for building frontline epidemiologic and emergency capacity in state and local jurisdictions. Through FY 2005, the program enrolled and trained 80 EIS officers CEFOs, with recruitment efforts that will lead to maintaining this level.
- In September 2006, CDC completed its current cycle of expansion to 20 quarantine stations at 20 international ports of entry into the U.S.; 18 of the 20 stations are staffed with at least one person. Quarantine stations are currently drafting and completing public health Emergency Response Plans. Emergency Response Plans will be drafted and integrated with local quarantine system partners at 18 ports of entry by September 2007. CDC is continuing to enhance the CDC Quarantine Network through expanded field presence, community partnership, preparedness and response activities, and increased surveillance and epidemiologic research. Quarantine Station expansion and enhancement has improved the systematic collection, analysis, interpretation, and dissemination of data related to public health events at U.S. ports of entry. This improves CDC's capacity to respond to natural and intentional communicable disease emergencies of public health significance.
- The Epi-X Program made Epi-X available in all 50 states and in 87 major metropolitan areas and increased the number of state and local public health professionals who use Epi-X to share intelligence regarding outbreaks and other emerging health events to over 3,300 professionals nationwide. An increased number of authorized and active Epi-X users allows for the rapid dissemination of information about emerging threats and possible terrorist activities to the affected or potentially affect public health professionals.
- The Epi-X Communications project is progressing towards its goal of 150 states and metropolitan areas having access to Epi-X; to date, 129 areas have access, with over 4,220 active users nationwide, surpassing the FY 2006 target of 3,200. An increased number of authorized and active Epi-X users allows for the rapid dissemination of information about emerging threats and possible terrorist activities to the affected or potentially affected public health professionals.

#### **CONTROL**

This goal allows for opportunities to create structures to provide immediate information and medication, if needed to those affected by a threat to the public's health. It also provides for planning and training to quickly receive and distribute the Strategic National Stockpile (SNS), a national repository of life saving pharmaceuticals, medical material and equipment. The final components, stated in three goals, relate to assuring that State and local health departments in conjunction with federal teams can quickly restore services, and learn and improve from each event.

#### GOAL 6: DECREASE THE TIME NEEDED TO PROVIDE COUNTERMEASURES AND HEALTH GUIDANCE TO THOSE AFFECTED BY THREATS TO THE PUBLIC'S HEALTH

##### Current Activities

- All 50 states, five territories, three freely associated states of the Pacific, the District of Columbia, and three major U.S. cities participate in the Health Alert Network (HAN), allowing for the high-speed exchange of critical

public health information to improve the practice of public health; providing linkages between all local public health jurisdictions via continuous, high speed, secure connections.

- CDC, through the SNS, acquires, manages, and deploys the nation's stockpile of life saving pharmaceuticals and other medical assets for a response to a terrorist event or other type public health emergency. Portions of the stockpile are configured in 50-ton, 12-Hour Push Packages that contain supplemental medicine and medical supplies designed to be deployed rapidly and used in the event of mass casualty incidents. These packages can be delivered to any point in the country within 12 hours of a Federal decision to deploy. Additionally, SNS assists state and local planners with the receipt, staging, storage, distribution, and dispensing of SNS assets.
- CDC is continuing with the Cities Readiness Initiative (CRI) that began in FY 2004 by providing special funding targeted to 21 selected cities / Metropolitan Statistical Areas (MSAs). Designed with a goal of helping these areas deliver medicines and medical supplies during a large-scale public health emergency such as a terrorist attack or natural disaster, funding is being expanded to incorporate additional geographic areas within these metropolitan regions, which were not included in the CRI Pilot. Additional funding is also being provided to conduct planning activities for the next phase of selected CRI cities. The intent of the targeted and expanded funding is to develop plans and infrastructure so that these selected cities (defined as the metropolitan area) are prepared to provide oral medications during an event to their entire population within 48 hours. Ongoing levels of collaboration between CDC, the United States Postal Service (USPS), and other federal agencies to develop successful strategies for support of the CRI will also continue in FY 2007.
- CDC is working towards the achievement of 100 percent preparedness of state public health agencies regarding the use of materials contained in the SNS as demonstrated by evaluation of standard functions that are determined by CDC. At the end of FY 2006, 70 percent (38 out of 54 project areas) of state public health agencies met the minimum standards for demonstrating preparedness to use SNS assets.
- CDC continues to collaborate with HHS to conduct pandemic preparedness summits with public health and emergency management and response leaders in each state. The purpose of these summits is to enhance state and local preparedness and to better prepare the nation for an influenza pandemic. The Division of State and Local Readiness (DSLR) is participating as technical experts in these summits. DSLR also coordinated the development of a 'request for applications' to allow state and local public health agencies to apply for and receive supplemental funds for pandemic preparedness.

#### Significant Accomplishments

- All state public health partners have developed or are in the process of developing a statewide communication system capable of sending and receiving critical health information during an emergency response event, 24/7.
- Prior to August 2005, the Federal Medical Station (FMS) program consisted of four prototype units (approximately 1000 beds) designed for a low to mid-acuity patient hospital bed surge mission. Hurricanes Katrina and Rita triggered the rapid development of FMS from prototype to deployable capacity resulting in the deployment of 5,500 beds to provide care for the victims of these disasters. Given the extensive medical needs created by the hurricanes, the operation of the shelters expanded to include the care of non-hospitalized patients with medical needs exacerbated by the disaster.
- Two successful FMS prototype demonstrations were conducted in Atlanta and Denver. During these exercises, HHS tested admission procedures, triage, patient care processing, infection control, transportation, and logistics functions. In Denver, approximately 112 medical surgical and pediatric patients were triaged. These tests demonstrated that FMS resources can quickly be integrated into existing hospitals resources to increase the supply of hospital beds and medical services in time of a national emergency.
- During FY 2004 and 2005, CDC purchased a large number of anthrax antibiotics, chemical antidotes, and influenza countermeasures.
- CDC has increased the number of Technical Advisory Response Unit (TARU) teams to six. A TARU consists of a seven to nine member team deployed by the CDC in the event of a national emergency to support state and local officials in requesting, receiving, and managing SNS assets. These teams provide expertise in the management of the 12-hour Push Package and technical assistance at receive, store and stage (RSS) sites.

#### **RECOVER**

CDC supports continuous improvements and analysis of knowledge gained to provide useful information for future responses. These goals also set the stage for rapid re-establishment of vital public health services for non-emergency conditions.

**GOAL 7: DECREASE THE TIME NEEDED TO RESTORE HEALTH SERVICES AND ENVIRONMENTAL SAFETY TO PRE-EVENT LEVELS**

**Current Activities**

- CDC is developing standardized tests that clearly indicate if viable bioterrorism agents are still present on environmental surfaces in a previously contaminated building or office.
- The CDC has identified specific categorical areas of equipment and supply shortages for plague and tularemia events, and subsequently, compiled detailed lists of needed supplies, and calculated associated acquisition costs. Procurement of these resources occurred in FY 2006.

**Significant Accomplishments**

- Following the tsunami emergency, CDC provided immediate multinational relief and rapid needs assessment to determine the suitability of health care infrastructure in the affected countries.

**GOAL 8: INCREASE THE LONG-TERM FOLLOW-UP PROVIDED TO THOSE AFFECTED BY THREATS TO THE PUBLIC'S HEALTH**

**Current Activities**

- CDC initiated a strategic partnership with key public health nursing professional groups to enhance public health capacity at the state/local level and assist CDC in meeting its goal to improve health impact.
- CDC is examining the link between physical and mental illness, trauma and violence, and preparedness, to gain a better understanding of the psychological and behavioral responses to terrorism to enhance and thereby enable CDC to build resiliency in the nation's communities.

**Significant Accomplishments**

- A draft of the Community Recovery and Preparedness Guide has been completed and is awaiting final review from an expert panel. This document will improve CDC's ability to measure and track healthy rebuilding at the community level.

***IMPROVE***

The final goal includes requirements for robust tracking of lessons learned and implementation of corrective actions to support enhanced response in the future. This constant re-evaluation is designed to ensure maximum efficiency and the best possible response to those affected by a CBRN or other public health emergency.

**GOAL 9: DECREASE THE TIME NEEDED TO IMPLEMENT RECOMMENDATIONS FROM AFTER-ACTION REPORTS FOLLOWING THREATS TO THE PUBLIC'S HEALTH**

**Current Activities**

- CDC is developing and disseminating web-based education and information materials to clinician audiences, which will enhance the nation's ability to respond to injuries from terrorism and natural disasters. These materials are expected to fill gaps in existing knowledge regarding injuries from terrorism.
- CDC is working with partner organizations to determine how to best represent the performance information collected in the past to allow for a snapshot of preparedness across the country.

**Significant Accomplishments**

- In May 2005, CDC released guidance for the Public Health Emergency Preparedness Cooperative Agreement. As part of this comprehensive guidance, CDC developed a performance framework to help guide the applicants in developing their application for funds and, more importantly, to establish a national system to measure public health system response performance. Over the past year, CDC has worked with subject matter experts from state and local public health agencies and laboratories, national partner organizations, and the federal government to refine these measures. The performance framework consists of the following components:
  - Section 1.01: Preparedness goals, which form a framework for public health activities related to preparedness -- Capabilities, integrated from the Targeted Capabilities List, which provides a comprehensive description of the major roles and capabilities needed to respond to an event of significance.

- Section 1.02: Required critical tasks, which are public health specific tasks associated with a capability
  - Performance measures, defined as leading indicators that will allow a national "snapshot" to show how the preparedness and response activities, and the associated resources, aid in making a public health system that responds more quickly and comprehensively in a public health emergency.

**OUTPUT TABLE**

OUTPUT TABLE	FY 2006 ACTUAL	FY 2007 CR	FY 2008 BUDGET	FY 2008 +/- FY 2007
Percent of state health departments that acknowledge receipt of Health Alert messages within 30 minutes of delivery 24/7.	70%	75%	75%	0
No. of network and other partnerships who distribute or deliver CDC and PHTN training and education to target audiences.	10	10	10	0
No. of state and local public health agencies in key jurisdictions that access BioSense data regularly to monitor for possible events	70	96	96	0
Academic Centers for Public Health Preparedness	27	27	0	(27)
No. of local health departments developing advanced information technology in support of terrorism preparedness and response	5	5	5	0
No. of U.S. quarantine and border health stations at U.S. international airports and other selected ports of entry	20	20	Up to 25	Up to 5
No. of veterinary and food laboratories in the LRN	28	28	28	0
No. of states, territories, and major metropolitan areas formally assessing public health capacity and preparedness	62	62	62	0
Percent of state health departments that have interoperable redundant communication systems.	30%	35%	35%	0

**FUNCTIONAL TABLE**

Terrorism (Dollars in Thousands)	FY 2006 Actual	FY 2007 CR	FY 2008 Budget	FY 2008 +/- FY 2007
<b>Upgrading State and Local Capacity</b>	\$823,099	\$823,674	\$698,267	(\$125,407)
<b>Upgrading CDC Capacity</b>	\$136,504	\$136,592	\$136,592	\$0
<b>Anthrax</b>	\$13,851	\$13,860	\$0	(\$13,860)
<b>BioSurveillance Initiative</b>	\$133,380	\$78,431	\$88,181	\$9,750
<b>Strategic National Stockpile</b>	\$524,339	\$491,390	\$581,335	\$89,945
<b>Total</b>	<b>\$1,631,173</b>	<b>\$1,543,947</b>	<b>\$1,504,375</b>	<b>(\$39,572)</b>

## REIMBURSEMENTS AND TRUST FUNDS

### AUTHORIZING LEGISLATION

PHSA §§ 301, 306(b)(4)<sup>1</sup>, 353, Clinical Laboratory Improvement Act, User fee: Labor-HHS FY Appropriations

REIMBURSEMENTS AND TRUST FUNDS (DOLLARS IN THOUSANDS)	FY 2006 ACTUAL	FY 2007 CR	FY 2008 BUDGET	FY 2008 +/ FY 2007
BA	\$505,933	\$521,111	\$536,744	\$15,633

### STATEMENT OF THE BUDGET

The FY 2008 Budget for Reimbursements and Trust Funds of \$536,744,000 reflects and increase of \$15,633,000 over the FY 2007 estimate of \$521,111,000.

### 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 example, CDC and the Department of the Interior implement a comprehensive program to eliminate Hepatitis B Virus (HBV) transmissions in the U.S.-affiliated Pacific Islands by including Hepatitis B vaccine into infant immunization schedules and catch-up vaccination programs for children up to six years old. These programs have led to a dramatic reduction in disease in this area and serve as a model for other programs in the U.S. and around the world. In another agreement, CDC works with the National Cancer Institute on the 5-A-Day for Better Health Program, a national nutrition education program that encourages all Americans to eat more vegetables and fruit for good health. CDC serves as the primary point of contact for the program and collaborates with NCI on nutrition behavior change, intervention and program evaluation research, surveillance, and epidemiology. Also, CDC and the Central Intelligence Agency (CIA) collaborate to sequence the genomes of several viral species important to bioterrorism defense, particularly variola. Variola, the causative agent for smallpox, is considered to be the most dangerous of pathogens with potential use for bioterrorism.

As part of the Comprehensive Cancer Control Leadership Initiative, CDC partners with the National Cancer Institute (NCI), the American Cancer Society (ACS), and 10 additional governmental and non-governmental organizations. The purpose of this initiative is to help leverage comprehensive cancer control efforts made at federal, state, and local levels. As a national convening partner, CDC works with NCI and ACS to plan series of initiatives that focus on implementing comprehensive cancer control plans with the states, tribes, and territories.

The Federal Technology Transfer Act (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. Under a current CRADA, CDC and Clean Air Filter® are developing reliable field testing methods for air quality inside equipment, such as bulldozers and drilling machines, used in surface mining operations. This research will aid in development of more effective air filters for mining equipment and protect equipment operators from exposure to harmful levels of silica dust.

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.

### RATIONALE FOR THE BUDGET

The FY 2008 Budget for Reimbursements and Trust Funds of \$536,744,000 reflects and increase of \$15,633,000 over the FY 2007 estimate of \$521,111,000.

**OUTPUT TABLE**

OUTPUT TABLE (DOLLARS IN THOUSANDS)	FY 2006 ACTUAL	FY 2007 CR	FY 2008 BUDGET	FY 2008 +/- FY 2007 ESTIMATE
<b>Agency for International Development</b> 11 Agreements for various projects, an infectious disease project, and family planning logistics.	\$24,468	\$25,202	\$25,959	\$757
<b>Department of Agriculture</b> 4 Agreements for various projects, National Nutrition Monitoring, NHANES 2002, to support active Surveillance Systems for bacterial diseases in the U.S.	\$1,745	\$1,797	\$1,851	\$54
<b>Department of Commerce</b> 2 Agreements for various projects, Develop Standards for Respiratory Protection Equipment and National Death Index Services.	\$1,839	\$1,894	\$1,951	\$57
<b>Department of Defense</b> 15 Agreements to perform various tasks such as Biowatch.	\$8,587	\$8,845	\$9,111	\$266
<b>Department of Energy</b> 7 Agreements for various projects including energy related analytical epidemiological research.	\$7,174	\$7,390	\$7,611	\$221
<b>Department of Health and Human Services</b> 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.	\$338,157	\$348,302	\$358,751	\$10,449
<b>Department of Homeland Security</b> 3 Agreements to evaluate and assess fire prevention grants to firefighters, and for National Pharmaceutical Stockpile and Smallpox activities.	\$25,662	\$26,431	\$27,224	\$793
<b>Department of Housing and Urban Development</b> 3 Agreements for Healthy Homes Initiatives, Lead-Based Paint Hazard Control, and inspections and risk assessments of project-based rental assisted housing.	\$800	\$824	\$849	\$25
<b>Department of Interior</b> 3 Agreements for various projects: Understanding of the Geography and Pathway of West Nile virus, and for the Pacific Emergency Health Initiative.	\$134	\$138	\$142	\$4

NARRATIVE BY ACTIVITY  
REIMBURSEMENT AND TRUST FUNDS

<b>OUTPUT TABLE (DOLLARS IN THOUSANDS)</b>	<b>FY 2006 ACTUAL</b>	<b>FY 2007 CR</b>	<b>FY 2008 BUDGET</b>	<b>FY 2008 +/- FY 2007 ESTIMATE</b>
<b>Department of Justice</b> 5 Agreements for the evaluation of hand-held assays for threat agents.	\$1,887	\$1,944	\$2,002	\$58
<b>Department of Labor</b> 4 Agreements to perform various tasks: NIOSH response to Energy Employees Occupational Illness, and space commodities and support services.	\$65,851	\$67,827	\$69,861	\$2,034
<b>Department of State</b> 2 Agreements for Consultation and Assistance in Addressing Refugee Health Needs, for ICASS-IAG Working Group Chairperson, and Decontamination of State Annex 32.	\$1,001	\$1,031	\$1,062	\$31
<b>Department of Transportation</b> 2 Agreements for various projects including: carbon monoxide houseboats study and for a public health assessment	\$150	\$155	\$159	\$4
<b>Environmental Protection Agency</b> 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.	\$1,598	\$1,646	\$1,695	\$49
<b>Federal Emergency Management Agency</b> 4 Agreements for health monitoring of response and recovery personnel in New York City.	\$19,214	\$19,790	\$20,384	\$594
<b>Various Agencies/Organizations</b> 29 Agreements for various projects with various agencies and organizations	\$4,296	\$4,424	\$4,557	\$133
<b>User Fees</b>	\$3,370	3,471	3,575	\$104

## AGENCY FOR TOXIC SUBSTANCES AND DISEASE REGISTRY

### AUTHORIZING LEGISLATION

The Great Lakes Critical Programs Act of 1990, 33 U.S.C. § 1268 Section 104(i) of the Comprehensive Environmental Response, Compensation and Liability Act of 1980 (CERCLA), as amended by the Superfund Amendments and Reauthorization Act of 1986 (SARA), 42 U.S.C. § 9604(i) The Defense Environmental Restoration Program, 10 U.S.C. § 2704 The Resource Conservation and Recovery Act, as amended, 42 U.S.C. § 321 et seq. The Clean Air Act, as amended, 42 U.S.C. § 7401 et seq.

	FY 2006 Actual	FY 2007 CR	FY 2008 Budget	FY 2008 +/- FY 2007
BA	\$74,905	\$74,905	\$75,004	\$99

### STATEMENT OF THE BUDGET

The FY 2008 Budget of \$75,004,000 for ATSDR represents an increase of \$99,000 above the FY 2007 Continuing Resolution level of \$74,905,000. The additional funding will be used for ATSDR's state cooperative agreement to develop environmental health capacity, provide health education, and conduct health outcome data reviews related to potential exposures to hazardous substances and toxic chemicals.

### PROGRAM DESCRIPTION

ATSDR is the nation's public health agency for chemical safety. The agency's mission is to use the best science, take responsive action, and provide trustworthy health information to prevent and mitigate harmful exposures and related disease.

Created in 1980 by CERCLA, commonly known as the Superfund law, ATSDR leads federal public health efforts at Superfund and other sites with known or potential toxic exposures. In FY 2006, ATSDR served over 3.2 million people in 346 communities.

ATSDR shares common concerns with other federal agencies, such as the Environmental Protection Agency (EPA), the National Institute of Occupational Health and Safety (NIOSH), and the Chemical Safety and Hazard Investigation Board (CSHIB). What distinguishes ATSDR is its unique focus. In the area of toxic substances, other federal agencies' efforts address substances in the environment and/or the workplace. ATSDR concentrates almost exclusively on the *human health effects* of substances in the environment. A non-regulatory agency, ATSDR often serves in an advisory capacity to other agencies, delivering authoritative scientific expertise on the human health effects of hazardous environmental exposures. ATSDR's programs are also distinctive in their emphasis on both community involvement and environmental justice.

In support of its strategic goals, ATSDR conducts a variety of activities, including the following:

- *Exposure Investigations* to collect and analyze site information and perform biological tests, and when appropriate, determine whether people have been exposed to hazardous substances.
- *Public Health Assessments* (PHAs) to review information about hazardous substances found at a waste site. PHAs evaluate whether people living or working at the site or nearby may be exposed to harmful levels of these substances. These assessments may also recommend that EPA or other agencies take certain actions to protect public health such as conducting blood tests for children or remediating a waste site. ATSDR conducts a PHA for each site proposed for the NPL and for other sites in response to petitions from communities.
- *Health Consultations* to provide guidance on specific, health-related questions about hazardous wastes in communities. More limited in scope than PHAs, health consultations may be written or oral, and may contain recommendations.
- *Toxicological Profiles* to summarize, interpret, and evaluate available data and possible health effects of hazardous substances found at NPL sites. To date, 289 toxicological profiles have been published or are under development. Of these, 274 profiles have been published as final, eight are being revised on the basis of public comments, and seven are out for public comment. The *ToxProfiles* are regularly updated and are used by health and scientific professionals worldwide.

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- *Health Education* to provide information and training to affected communities and medical professionals about ways to assess, control, or prevent exposure to hazardous substances in the environment.
- *Health Studies* to help determine whether exposures to hazardous substances can lead to increased risk for various health problems, such as cancer, birth defects, auto-immune or neurological disorders, respiratory diseases, and other illnesses. ATSDR conducts its own health studies and supports others through agreements with state health departments and universities.
- *Health Registries* to document exposures to toxic substances and health effects potentially associated with such exposures. Registries can help scientists understand the extent of exposures and provide data that can be used to demonstrate or disprove links between exposures and health outcomes.
- In addition, ATSDR helps protect public health during emergencies by providing resources, staff, and technical assistance when needed anywhere in the United States.

### **RATIONALE FOR THE BUDGET**

The FY 2008 Budget of \$75,004,000 for ATSDR represents an increase of \$99,000 above the FY 2007 Continuing Resolution level of \$74,905,000. The additional funding will be used for ATSDR's state cooperative agreement to develop environmental health capacity, provide health education, and conduct health outcome data reviews related to potential exposures to hazardous substances and toxic chemicals.

### **PERFORMANCE ANALYSIS**

#### PART Results

Since ATSDR's PART Audit in 2003, ATSDR has taken a number of steps to achieve efficiencies and to improve program performance. For example:

- In FY 2005, the National Center for Environmental Health (NCEH) and ATSDR completed a consolidation of their respective Offices of the Director and a consolidation of their external advisory boards. NCEH/ATSDR's new board, the Board of Scientific Counselors (BSC), composed of subject matter experts, were charged with providing peer review evaluation of all agency programs. Since 2004, the BSC has completed five program reviews and plans to complete approximately three reviews annually.
- ATSDR's consolidation with NCEH to improve administrative efficiencies within the two agencies.
- ATSDR continues to track and report on project performance and has instituted a new policy requiring partners to report impacts of interventions and to align these activities with ATSDR's long-term goals and measures. The Agency has developed performance-tracking and measurement systems in accordance with CDC's budgeting and performance software database. ATSDR also tracks performance and budget information through internal project and performance databases.
- ATSDR instituted new evaluations for interventions at sites with the most urgent public health hazards. As a result, ATSDR has been able to collaborate with state partners and the Environmental Protection Agency (EPA) to achieve important public health outcomes.

#### Current Activities

- ATSDR plays a significant role in planning for and responding to natural and man-made large-scale public health emergencies. Located in EPA regional offices, regional ATSDR staff work with EPA and state partners on a daily basis to ensure immediate access to local expertise in planning for and responding to chemical emergencies. An example from FY 2006 is ATSDR's extensive response to the public health emergency that followed Hurricane Katrina.
- ATSDR continues its efforts in mitigating and preventing health risks at sites by providing PHAs, Health Consultations, technical assistance, and other services that aid officials in making appropriate public health decisions. The agency is also reviewing ways to improve its ability to provide more timely assistance by greatly accelerating the agency's reporting of exposure and risk evaluations.
- ATSDR continues to study Multiple Sclerosis/Amyotrophic Lateral Sclerosis (MS/ALS) prevalence in Oregon and Massachusetts. The Agency is also conducting case-control MS studies in Ohio,

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Massachusetts, Missouri, and Texas, and is conducting pilot projects in Georgia, South Carolina, and Minnesota to help determine the feasibility of creating a national ALS registry. Pilot projects to determine the feasibility of developing the MS registry are currently being conducted in New York and Arizona.

- ATSDR remains focused on determining the relationship between toxic exposures and disease. Through the development of its toxicological profiles, health studies, disease tracking projects, and surveillance studies, the Agency improves the science base for environmental public health decision-making by filling the gaps in knowledge about human health effects from exposure to hazardous substances.
- ATSDR is helping protect Americans from exposures to asbestos fibers and resulting health effects. Over 200 facilities around the country received and processed vermiculite ore from Libby, Montana, which is known to have contained asbestos. ATSDR's National Asbestos Exposure Review continues to investigate these sites and is helping local agencies to educate those who may have been exposed to the asbestos, particularly plant workers and their families, about preventing and coping with asbestos-related disease. ATSDR is also conducting the National Asbestos Health Program, which offers screening of exposed persons at vermiculite sites in New Jersey and California.
- Over 71,000 registrants in the World Trade Center Health Registry, launched in September 2003, will be interviewed periodically over the next 20 years to track the long-term health effects of exposures during the event. The first follow-up interviews were conducted in November 2006. Data collected from participants on health outcomes will be analyzed and reported in quarterly newsletters and peer reviewed publications.

Significant Accomplishments

- *Protecting Firefighters and Residents* — ATSDR helped EPA responders protect the health of residents who lived near a major chemical fire in Connecticut. ATSDR's specialist advised on necessary protection measures for nearby residents, reoccupancy, and health consequences to responders of a chemical found in firefighting pond water. The specialist also caught a serious and potentially harmful error in concentration calculations and worked on assessment and cleanup measures for asbestos, which the fire's five-mile long smoke plume deposited into residential properties. As a result, health of residents and responders was protected from exposure to particulates, asbestos, and methyl methacrylate.
- *Preventing current and future hazardous exposures* — New legislation in New Jersey will soon prevent schools and day care centers from being built on contaminated property, following ATSDR's work with state health officials to protect children from mercury exposures at a day care center. The Kiddie Kollege Day Care Center in Franklin Township, New Jersey, was housed in a building once occupied by a company that made thermometers and related instruments. The manufacturing involved elemental mercury. Following ATSDR's and the State's guidance, all children and staff were advised to evacuate, and the day-care operator immediately closed the center. ATSDR, working with state health officials, the CDC Environmental Health Lab, and the Mt. Sinai Pediatric Environmental Specialty Health Unit, then arranged for mercury testing and education. Sixty children and nine adults received tests, which the CDC laboratory processed in extraordinarily rapid fashion. Repeat testing was offered to families and staff until all mercury levels were considered to be in an acceptable range.
- *Battling Lung Problems* — Thanks to a recent study and follow-up efforts by ATSDR and its state partner in Idaho, physicians and health professionals in Chubbuck and Pocatello will now be able to help their patients reduce their exposure to particulate matter and, consequently, lower their risk of lung disease. ATSDR provided health care professionals identified by the Idaho Department of Health and Welfare with information to help their patients. Health education materials were directed at the over 100 health professionals in Pocatello and Chubbuck areas specializing in children, seniors, lung patients, and family practice. Each was provided with the findings of the study and advised of ways patients can reduce their exposure to particulate matter in the air.
- *Finding Answers to Troubling Questions* — An ATSDR innovation is helping to answer lingering health questions at Marine Corps Base Camp Lejeune, North Carolina. Two decades have passed since contaminated drinking water wells were closed at the base, and for an uncertain period before that, some base families and personnel were exposed to volatile organic compounds (VOCs) in the water. ATSDR has been working on analyzing the extent of exposures. To compensate for the lack of information about the Camp's water distribution system operations for

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that period, ATSDR developed an innovative water model to assess likely past exposures. In part, the model development involved measuring flow rates and pressures at different locations along the water distribution system. The model will help identify the likely route, timeframe, and extent of exposure.

- *Identifying and Educating Exposed Workers* — ATSDR is working to protect the health of thousands of people who may have been exposed to asbestos from vermiculite-processing plants. In New York, ATSDR and the New York State Department of Health collaborated in getting past employees of a former vermiculite exfoliating facility in Weedsport to seek medical evaluation. ATSDR and NYSDOH prompted former workers and their families of the importance of medical evaluation because of their potential exposure. As a result of the evaluations, several people found that they had asbestos-related disease. In Pennsylvania, ATSDR found that some 60 to 120 workers at a New Castle plant were likely exposed to asbestos. In addition, the nearly 2,200 people who lived within a mile of the plant in 1990 may also have been exposed while the plant was in operation. Although little can be done about past exposures, education efforts can help lead those with established or potential asbestos exposures to reduce behaviors (e.g., cigarette smoking) known to increase the risk of developing asbestos-related disease.
- *Responding to Hurricane Katrina* — Immediately following Hurricane Katrina, ATSDR staff deployed to the area to work with EPA in resolving public health issues. Specifically, ATSDR personnel:
  - Helped assess and reopen approximately 200 schools in Jefferson Parish;
  - Delivered technical support to local and state officials on environmental health issues (e.g., infection control, potable water, waste water, food services, sleeping areas) to protect the health of survivors, evacuees, and response personnel;
  - Helped assess safety of environmental chemical exposures;
  - Helped rebuild the New Orleans Environmental Health Department's functionality;
  - Aided EPA during abatement of chemical spills in Mississippi; and
  - Worked with EPA, the Coast Guard, and other responders to avert widespread hazardous exposures for thousands of people. For example, ATSDR staff helped:
    - Search for, collect, or remediate potential industrial and residential hazards, such as dislodged or leaking fuel tanks, chlorine and propane cylinders, hospital biohazards, and 55-gallon chemical drums the storms floated from barges to front lawns;
    - Survey rail lines for damaged or leaking chemical and freight cars;
    - Investigate industrial facilities, including a chemical plant, to determine whether these facilities posed hazards as a result of hurricane damage;
    - Deliver critical health guidance to returning residents on carbon monoxide, water sanitation, electrical hazards, and other topics; and
    - Evaluate NPL sites in the area for hazards following the storms.
- *Protecting Children from Asthma* — Findings from a study of two New York City boroughs, Bronx and Manhattan, may help people reduce exposure to ambient air pollutants and emergency department visits due to acute asthma. The study conducted by the New York State Department of Health in cooperation with ATSDR, suggests that the criteria pollutants such as particulate matter, sulphur dioxide, ozone, and nitrous oxide had statistically detectable impact on acute asthma emergency department visits in a community with a relatively high baseline rate of acute asthma exacerbations.
- *What You Don't Know* — ATSDR helped uncover critical new health information for some former workers at the Stauffer Chemical Company plant in Tarpon Springs, Florida. The plant produced elemental phosphorous and had approximately 2,500 employees from 1941 to 1981. Workers were exposed to mixture of respiratory irritants including toxic chemicals, gases, and other substances, including asbestos. ATSDR evaluated the health of 36 former workers who volunteered for testing. The evaluation revealed that a number of the workers had medically significant conditions, some of which were undetected previously. In identifying this information, ATSDR helped the workers protect their own health and advanced environmental medicine in the community.

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- *Protecting Thousands of Residents from Asbestos Debris* — ATSDR worked with EPA to protect the health of some 5,000 – 8,000 residents evacuated during a fire at the AMACOR magnesium recycling facility in Anderson, Indiana. ATSDR helped determine where air-monitoring equipment needed to be located to be effective. The fire burned for about 48 hours, and roofing material was blown from the buildings and scattered around the surrounding residential community. The impacted area covered a two-mile radius and affected approximately 1,300 residences. ATSDR and others developed a neighborhood clean-up clearance sampling protocol to help protect against residential exposures to asbestos-containing debris potentially left behind after the clean up.

**OUTPUT TABLE**

OUTPUT TABLE	FY 2006 ACTUAL	FY 2007 CR	FY 2008 BUDGET	FY 2008 +/- FY 2007
Cooperative Agreements	31	31	31	0
Sites Evaluated/Chemical Release Responses	742	730	730	0
Public Health Assessments/Health Consults (includes chemical specific health consults)	527	526	526	0
Technical Assists	10,429	7,062	7,162	100
Exposure Investigations	8	8	9	1
Emergency Responses and Exercises	58	58	58	0
Health Studies	45	43	45	2
Surveillance (# of states) and Registries (# of registries by exposure type)	17	11	11	0
Hazardous Substances Emergency Event Surveillance (states and events)	14 states/ 8,062 events	14 states/ 8,062 events	14 states/ 8,062 events	0
Great Lakes Research Projects (grants)	5	5	5	0
Minority Health Professions Foundation (studies)	7	5	5	0
Toxicological Profiles	13	13	13	0
Information Dissemination	6,859,883	7,000,000	7,400,000	400,000
Pediatric Environmental Health Specialty Units	11	11	11	0
Health Professionals Trained	60,970	63,600	63,600	0
Community Members Educated	142,943	133,000	133,000	0

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# **PERFORMANCE DETAIL**

**EFFECTS OF CONTINUING RESOLUTION ON PERFORMANCE TARGETS**

Given the uncertainty of final FY 2007 appropriation levels at the time CDC developed the performance targets for the FY 2008 Congressional Justification, the FY 2007 targets were not modified to reflect differences between the President's Budget and the Continuing Resolution funding levels. Enacted funding may require modifications of the FY 2007 performance targets. Only one performance measure, located in the Environmental Health section, reflects an adjustment in its FY 2007 target due to the Continuing Resolution.

PERFORMANCE DETAIL  
SUMMARY OF PERFORMANCE TARGETS AND REPORTING PERFORMANCE MEASURES

**SUMMARY OF PERFORMANCE TARGETS AND REPORTING PERFORMANCE MEASURES**

The table below provides a summary of CDC's performance measures.

SUMMARY OF TARGETS AND RESULTS							
FY	Total Targets	Results Reported		Targets			
		Number	%	Met	Not Met		% Met
					Total	Improved	
2003 <sup>1</sup>	131	128	98%	95	33	8.3	74%
2004 <sup>2</sup>	90	82	91%	53.61	28.39	10.39	65%
2005 <sup>3</sup>	134	107	80%	72.84	34.16	12.16	68%
2006 <sup>3</sup>	148	87	59%	70.67	16.33	7.5	81%
2007 <sup>3</sup>	121	N/A	N/A	N/A	N/A	N/A	N/A
2008 <sup>3</sup>	121	N/A	N/A	N/A	N/A	N/A	N/A

<sup>1</sup> FY 2003 data have been revised based on updated information.

<sup>2</sup> FY 2004 reflects the results of multiple targets for some measures within the performance plan.

<sup>3</sup> FY 2005 – FY 2008 performance plans include one measure which is double-counted, serving as both an efficiency measure and an outcome measure as a result of the 2005 PART process.

**PERFORMANCE DETAIL  
PROGRAM ASSESSMENT RATING TOOL (PART) SUMMARY TABLE**

**PROGRAM ASSESSMENT RATING TOOL (PART) SUMMARY TABLE**

PROGRAM	(DOLLARS IN MILLIONS)			NARRATIVE RATING
	FY 2007 CR	FY 2008 BUDGET	FY 2008 +/- FY 2007	
<b>2002 PART Programs</b>				
317 Immunization Program	\$425.1	\$425.1	\$0	Adequate
Breast and Cervical Cancer	\$201.4	\$201.4	\$0	Adequate
Diabetes	\$62.8	\$62.8	\$0	Adequate
Domestic HIV/ AIDS Prevention	\$652.1	\$745.1	\$93.0	Results Not Demonstrated
<b>2003 PART Programs</b>				
State and Local Preparedness <sup>1</sup>	\$823.7	\$698.3	(\$125.4)	Results Not Demonstrated
<b>2004 PART Programs</b>				
Buildings and Facilities	\$133.6	\$20.0	(\$113.6)	Adequate
Occupational Safety and Health	\$253.0	\$253.0	\$0	Adequate
Infectious Diseases Control <sup>2</sup>	N/A	N/A	N/A	Adequate
Sexually Transmitted Diseases / Tuberculosis	\$294.1	\$294.1	\$0	Adequate
<b>2005 PART Programs</b>				
Environmental Health	\$149.3	\$149.3	\$0	Adequate
Global AIDS Program	\$121.2	\$121.2	\$0	Focus Countries – Moderately Effective; <u>Other Bilateral</u> - Adequate
Global Immunization	\$144.4	\$144.4	\$0	Effective
Health Statistics	\$109.0	\$109.9	\$0.9	Moderately Effective
Strategic National Stockpile	\$491.4	\$581.3	\$89.9	Moderately Effective
<b>2006 PART Programs</b>				
Chronic Disease Prevention	\$834.2	\$834.2	\$0	Moderately Effective
Birth Defects and Developmental Disabilities	\$124.5	\$124.5	\$0	Moderately Effective
Injury Prevention and Control	\$138.4	\$138.4	\$0	Moderately Effective
Biosurveillance	\$78.4	\$88.2	\$9.8	Results Not Demonstrated
Bioterrorism: Upgrading CDC Capacity	\$136.6	\$136.6	\$0	Results Not Demonstrated

<sup>1</sup> Funding levels for State and Local Preparedness reflect the entire Upgrading State and Local Capacity line.

<sup>2</sup> Infectious Diseases has been reorganized and no longer exists as a budget item.

<sup>3</sup> Funding does not include transfers to CDC from the Department of State Office of the Global AIDS Coordinator (\$603.7 million to date in FY 2006), as part of the Emergency Plan for AIDS Relief.

Funding requested for FY 2008 will allow CDC's PART programs to continue working toward their long-term and annual performance goals and measures, as well as actions to enhance program performance. Progress toward these goals and measures are reported in the Detail of Performance Analysis in the Performance Detail section.

For those programs with a Results Not Demonstrated (RND) rating, including Domestic HIV/AIDS Prevention and State and Local Preparedness, CDC recommends that funding be continued at requested levels because of the

PERFORMANCE DETAIL  
PROGRAM ASSESSMENT RATING TOOL (PART) SUMMARY TABLE

significant progress being made toward the programs' PART Recommendations. Further, both programs anticipate undergoing a comprehensive PART re-review during the 2007 budget cycle.

For the 2006 cycle, CDC had five programs undergo the PART process: Chronic Disease Prevention, Birth Defects and Developmental Disabilities, Injury Prevention and Control, Biosurveillance, and Bioterrorism: Upgrading CDC Capacity. A brief overview of PART review findings and recommendations is provided in the narrative justifications for CDC programs that were assessed through PART in CY 2002 – CY 2006. Further detail may be found at [www.ExpectMore.gov](http://www.ExpectMore.gov).

## DETAIL OF PERFORMANCE ANALYSIS

The legend below provides detail for the icons referenced within the Detail of Performance Tables. Note the addition of the Secretary's 500-Day Plan.

DETAIL OF PERFORMANCE LEGEND	
E	Efficiency Measure
HHS#	HHS Strategic Plan Goal
HP#	Healthy People 2010 Objective
O	Outcome Measure
PAR	Performance and Accountability Report
PART	Program Assessment Rating Tool
*#	President's Management Agenda Initiative
500#	Secretary's 500-Day Plan: 1 – Transform the Healthcare System 2 – Modernize Medicare and Medicaid 3 – Advance Medical Research 4 – Secure the Homeland 5 – Protect Life, Family, and Human Dignity 6 – Improve the Human Condition around the World

## INFECTIOUS DISEASES

### IMMUNIZATION AND RESPIRATORY DISEASES

Efficiency Measure	FY	Target	Result
1. Make vaccine distribution more efficient and improve availability of vaccine inventory by reducing the number of vaccine inventory depots in the U.S. [E]	2008	Reduce inventory depots by 50%	1/2009
	2007	Reduce inventory depots by approximately 17%	1/2008
	2006	Award contract to centralize distribution, validate existing baseline	Yes (Met)
	2005	Establish estimated baseline of inventory points in the contiguous states	>400 (Met)
<b>Data Source:</b> Grantee annual report (VFC Management Survey), grantee interviews, and site visits were used to gather the baseline information. A VMBIP semi-annual survey instrument is being developed and will be administered to grantees to track vaccine storage locations.			
<b>Data Validation:</b> Data submitted from grantees will be analyzed by the CDC program staff and validated through a regularly scheduled review process.			
<b>Cross Reference:</b> HHS-8			

#### Efficiency Measure 1:

The Vaccine Management Business Improvement Project (VMBIP) is a CDC initiative aimed at increasing the efficiency, visibility, and management of publicly purchased vaccines by centralizing and consolidating vaccine inventory and distribution. Currently, publicly purchased vaccine, including vaccine purchased by the Section 317 program, is held at various third party distribution depots or in state run depots. It is estimated that 400 storage locations exist. Even though the current system works, it is inefficient. The large number of depots results in redundancy of distribution resources, reduces the efficiency of distribution, and impedes the program's ability to track vaccine.

CDC, through VMBIP, contracted with McKesson Specialty Distribution in September 2006 to consolidate national inventory in significantly fewer inventory depots than currently exist and distribute vaccine through a streamlined central system. The expected efficiencies gained from consolidation of vaccine depots include improved management of vaccine inventory through use of distribution best practices and increased visibility of the location of vaccines throughout the public vaccine supply chain. As phased implementation progresses, the number of locations holding vaccines will decrease until full implementation is complete by FY 2009 and vaccine inventory depots are reduced by 98 percent. The first pilot sites which are Washington State, California, the City of Chicago, and Maryland will begin distributing through the centralized distribution system in February 2007.

GOAL 1: REDUCE THE NUMBER OF INDIGENOUS CASES OF VACCINE PREVENTABLE DISEASES.			
Measure	FY	Target	Result
1. The number of indigenous cases of paralytic polio <sup>1</sup> , rubella <sup>1</sup> , measles <sup>1</sup> , <i>Haemophilus influenzae</i> invasive disease (type b and unknown types) <sup>2</sup> , diphtheria <sup>3</sup> , congenital rubella syndrome <sup>4,5</sup> , and tetanus <sup>3</sup> will remain at or be reduced to 0 by 2010. [O]		Paralytic Polio	Paralytic Polio
	2008	0	9/2009
	2007	0	9/2008
	2006	0	9/2007
	2005	0	0 (Met)
	2004	0	0 (Met)
	2003	0	0 (Met)
		Rubella	Rubella
	2008	15	9/2009
	2007	15	9/2008

PERFORMANCE DETAIL  
INFECTIOUS DISEASES  
IMMUNIZATION AND RESPIRATORY DISEASES

**GOAL 1: REDUCE THE NUMBER OF INDIGENOUS CASES OF VACCINE PREVENTABLE DISEASES.**

<b>Measure</b>	<b>FY</b>	<b>Target</b>	<b>Result</b>
	2006	15	9/2007
	2005	15	8 (Exceeded)
	2004	15	7(Exceeded)
	2003	15	7 (Exceeded)
		<i>Measles</i>	<i>Measles</i>
	2008	<b>50</b>	9/2009
	2007	50	9/2008
	2006	50	9/2007
	2005	50	42 (Exceeded)
	2004	50	10 (Exceeded)
	2003	50	32 (Exceeded)
		<i>Haemophilus influenzae</i>	<i>Haemophilus influenzae</i>
	2008	<b>150</b>	9/2009
	2007	150	9/2008
	2006	150	9/2007
	2005	150	226 b = unknown (Unmet)
	2004	150	196 b + unknown (Unmet)
	2003	175	259 b+unknown (Unmet)
		<i>Diphtheria</i>	<i>Diphtheria</i>
	2008	<b>5</b>	9/2009
	2007	5	9/2008
	2006	5	9/2007
	2005	5	0 (Exceeded)
	2004	5	0 (Exceeded)
	2003	5	0 (Exceeded)
		<i>Congenital rubella Syndrome</i>	<i>Congenital rubella Syndrome</i>
	2008	<b>5</b>	9/2009
	2007	5	9/2008
	2006	5	9/2007
	2005	5	0 (Exceeded)
	2004	5	0 (Exceeded)
	2003	5	1 (Exceeded)
		<i>Tetanus</i>	<i>Tetanus</i>
	2008	<b>25</b>	9/2009
	2007	25	9/2008
	2006	25	9/2007
	2005	25	5 (Exceeded)
	2004	25	6 (Exceeded)
	2003	25	6 (Exceeded)

PERFORMANCE DETAIL  
INFECTIOUS DISEASES  
IMMUNIZATION AND RESPIRATORY DISEASES

**GOAL 1: REDUCE THE NUMBER OF INDIGENOUS CASES OF VACCINE PREVENTABLE DISEASES.**

Measure	FY	Target	Result
2. Reduce the number of indigenous cases of mumps in persons of all ages from 666 (1998 baseline) to 0 by 2010. [O] <sup>5</sup>		<i>Mumps</i>	<i>Mumps</i>
	2008	<b>200</b>	9/2009
	2007	200	9/2008
	2006	200	9/2007
	2005	200	314 (Unmet)
	2004	200	258 (Unmet)
	2003	250	231 (Exceeded)
3. Reduce the number of indigenous cases of pertussis among children under 7 years of age. [O]		<i>Pertussis</i>	<i>Pertussis</i>
	2008	<b>2,300</b>	9/2009
	2007	2,300	9/2008
	2006	2,300	9/2007
	2005	2,300	7,347 (Unmet)
	2004	2,300	6,850 (Unmet)
	2003	2,500	3,719 (Unmet)
<b>Data Source:</b> National Notifiable Disease Surveillance System (NNDSS), National Congenital Rubella Syndrome Registry (NCRSR), Active Bacterial Core Surveillance (ABCs), Emerging Infections Programs.			
<b>Data Validation:</b> <u>NNDSS</u> - CDC receives reports of notifiable diseases from the 50 state health departments, New York City, the District of Columbia, and five U.S. Territories. These reports are initiated when health care providers suspect or diagnose a case of a notifiable disease. Clinical laboratories also report results consistent with reportable diseases. Reporting of nationally notifiable diseases to CDC by the states is voluntary and only mandated (i.e., by state legislation or regulation) at the state level. All case reports, especially for low incidence and internationally quarantinable diseases, must be verified by the appropriate state officials. NNDSS case counts are likely incomplete, and therefore, these data are considered to represent a minimum number of cases. State reporting practices and some administrative procedures used in processing the NNDSS data may impact surveillance data reports and analyses. CDC staffs provide technical assistance relevant for data verification to ensure data accuracy, completeness, and timeliness. Specifically, assistance includes: computer specifications and software for reporting from state and territorial health departments, development and implementation of procedures to validate surveillance data, and identification of incomplete records, transmission errors, and deviations from expected numbers. <u>NCRSR</u> - CDC maintains the NCRSR with supplemental information to NNDSS. The registry includes data only on cases classified as confirmed or compatible. Cases are also classified as indigenous (exposure within the United States) and imported (exposure outside the United States) and are tabulated by year of birth. In contrast, cases reported to the NNDSS are tabulated by year of report. <u>ABCs</u> is an active laboratory and population-based surveillance system for invasive bacterial pathogens of public health importance, and currently operates in 10 sites in the U.S. For each case of invasive disease in the surveillance population, a case report with basic demographic information is completed and bacterial isolates are sent to CDC and other reference laboratories for additional laboratory evaluation. The ABCs program provides routine laboratory audits to ensure the completeness of data collection. Each month, CDC staff review data and communicate potential errors to state personnel for evaluation. Performance standards for active surveillance have been established in each site to permit aggregation of data collected via somewhat different approaches. Detailed instructions for completion of case report forms ensure consistency across sites. Timeliness and completeness of reporting in ABCs is evaluated using threshold percentages of isolate collection and enrollment into special studies. Surveillance "fatigue" or operational problems are assessed using isolate shipping schedules, audit sensitivities, and the timeliness of the audit data being completed by set deadlines.			
<b>Cross Reference:</b> <u>Measure 1</u> - HHS-1, HP-14.1a, 14.1b, 14.1c, 14.1e, 14.1h, 14.1i, 14.1j, PART, 500-1; <u>Measure 2</u> - HHS-1, HP-14.1f, 500-1; <u>Measure 3</u> - HHS-1, HP-14.1g, 500-1			

<sup>1</sup> All ages.

<sup>2</sup> Children under five years of age.

<sup>3</sup> Persons under 35 years of age.

<sup>4</sup> Children under one year of age. Result column indicates all cases – indigenous and imported. Imported cases will be differentiated in 2007, but those data are not yet available.

<sup>5</sup> Results column indicates all cases – indigenous and imported. Imported cases will be differentiated in 2007, but those data are not yet available.

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**Goal 1, Performance Measure 1:**

Haemophilus influenzae type B (Hib) – Conjugate vaccines for the prevention of Hib are highly effective. Hib is no longer the leading cause of meningitis among children younger than five years old in the U.S. The number of possible cases reported increased from 196 cases in 2004 to 226 cases in 2005, and the FY 2005 target of 150 cases remains unmet. In accordance with the Healthy People 2010 goal, this measure includes both type b cases (for which vaccine would be effective) and those with unknown serotypes. The number of cases with unknown serotypes that are actually type b cannot be confirmed. Neither Healthy People 2010 targets nor GPRA targets have been adjusted to account for cases with unknown serotype. Therefore, while this goal remains unmet, the actual number of type b cases (both serotyped and not) for which the vaccine would have been effective may have remained the same or even decreased; the increase in cases from 2004 to 2005 may be explained by these disease reporting challenges. To address this issue of incomplete serotyping, CDC is working with state partners to provide technical assistance for enhanced Hib surveillance and laboratory support.

**Goal 1, Performance Measure 2:**

Provisional data indicate that the mumps disease targets will not be met in 2005 or 2006 due to a large national mumps outbreak that began in December 2005 and continued through 2006. Although the highest number of cases was reported from states in the Midwest, most states reported increases in number of mumps cases. The majority of cases occurred among persons 18-25 years of age, many of these persons were vaccinated with two doses, reflecting the 90%-95% effectiveness of this vaccination schedule. As a result of this outbreak, vaccination recommendations were modified to better define evidence of immunity, ensure routine vaccination for health care workers, and address additional vaccination needs for persons in outbreak settings. Prior to 2004, there had been some progress in mumps disease reduction – reflected by a two-thirds reduction in cases from 1998 (666 cases) to 2003 (231 cases). However, the number of mumps cases in 2004 increased to 258 and CDC did not meet the 2004 goal of 200 cases.

**Goal 1, Performance Measure 3:**

Pertussis (whooping cough) is a highly contagious, vaccine-preventable bacterial illness characterized by prolonged and severe cough and sometimes pneumonia. Although pertussis affects all age groups, complications and death are most frequently recognized among unvaccinated infants. The 2005 target was to reduce the number of pertussis cases among children under seven years of age to 2,300. The actual number of cases in this age group was 7,347. Most of these cases occurred among children who are not fully protected from disease. Children are not fully protected until they receive four doses of the vaccine by 15-18 months. Many cases occur among infants who are exposed to disease before they receive their first vaccination at two months of age. Introduction in 2005 of adolescent and adult versions of improved acellular pertussis vaccines with tetanus and diphtheria booster (DTaP vaccine) provides new opportunities for reducing severe pertussis and its complications in all age groups in the U.S.

GOAL 2: ENSURE THAT 2 YEAR OLDS ARE APPROPRIATELY VACCINATED.			
Measure	FY	Target	Result
1. Achieve or sustain immunization coverage of at least 90% in children 19- to 35-months of age for:  -4 doses DTaP vaccine <sup>1</sup> -3 doses Hib vaccine -1 dose MMR vaccine <sup>2</sup> -3 doses hepatitis B vaccine -3 doses polio vaccine -1 dose varicella vaccine -4 doses pneumococcal conjugate vaccine (PCV7) <sup>3</sup>	2008	<b>90% coverage</b>	8/2009
	2007	90% coverage	8/2008
	2006	90% coverage	8/2007
	2005	90% coverage	DTaP 86%; Hib 94%; MMR 92%; Hepatitis B 93%; Polio 92%; Varicella 88% (Exceeded, with the exception of DTaP and Varicella)
	2004	90% coverage	DTaP 86%; Hib 94%; MMR 93%; Hepatitis B 92%; Polio 92%; Varicella 88% (Exceeded, with the exception of DTaP and Varicella)

**GOAL 2: ENSURE THAT 2 YEAR OLDS ARE APPROPRIATELY VACCINATED.**

Measure	FY	Target	Result
	2003	90% coverage	DTaP 96%; Hib 94%; MMR 93%; Hepatitis B 92%; Polio 92%; Varicella 85% (Exceeded, with the exception of Varicella)
<b>Data Source:</b> Data are collected through the National Immunization Survey (NIS) and reflect calendar years.			
<p><b>Data Validation:</b> The NIS uses a nationally representative sample and provides estimates of vaccination coverage rates that are weighted to represent the entire population, nationally, and by region, state, and selected large metropolitan areas. The NIS, a telephone-based survey, is administered by random-digit-dialing to find households with children aged 19 to 35 months. Parents or guardians are asked about the vaccines—with dates—that appear on the child's "shot card" kept in the home; demographic and socioeconomic information is also collected. At the end of the interview with parents or guardians, survey administrators request permission to contact the child's vaccination providers. Providers are then contacted by mail to provide a record of all immunizations given to the child. Examples of quality control procedures include 100% verification of all entered data with a subsample of records independently entered. The quarterly data files are reviewed for consistency and completeness by CDC's National Immunization Program, Immunization Services Division - Assessment Branch and CDC's National Center for Health Statistics' (NCHS) Office of Research and Methodology. NCHS also conducts a separate qualitative assessment of 10% of the records. Random monitoring by supervisors of interviewers' questionnaire administration styles and data entry accuracy occurs daily. Annual methodology reports are available to the public for review.</p>			
<b>Cross Reference:</b> HHS-1, HP-14.24a, PART, PAR, 500-1			

<sup>1</sup> Due to a shortage in vaccine and temporary change in recommendations, 3 doses were reported from 2002 – 2003.

<sup>2</sup> Includes any measles-containing vaccine.

<sup>3</sup> Performance targets for any newly recommended vaccines, such as pneumococcal conjugate and influenza vaccines, are reported in GPRA five years after an ACIP recommendation is made and once NIS data become available. The timing of data availability may also be impacted by the age group for which that particular vaccine is recommended.

#### **Goal 2, Performance Measure 1:**

The ACIP Recommended Childhood and Adolescent Immunization Schedule recommends routine vaccination of children for the above diseases. The target of 90 percent coverage was met in 2005 for most vaccines with the exception of varicella and the fourth dose of DTaP.

In 2005, the coverage rate for four doses of DTaP containing vaccine did not yet achieve the 90 percent goal. However, the coverage rate for the fourth dose has steadily increased since the change to a four dose schedule, as recommended by the ACIP in 1991. The ACIP also recommends that a fifth dose be given to children between four and six years of age for full vaccination. This goal continues to be difficult to achieve because it requires that the fourth dose be given to the child between 15 and 18 months of age. The administration of DTaP tends to coincide with regular well-baby visits through the third dose; however, the fourth dose does not, requiring a visit specifically for this purpose. Coverage rates are 96 percent for the first three DTaP doses. Although the first three doses are considered to be most critical, CDC and the ACIP feel strongly that the fourth dose and also the fifth dose are important for full vaccination. Varying state requirements for the four-dose vaccine schedule may have also led to a slower increase in coverage. In 2002 and 2003, CDC modified reporting on DTaP from four doses to three doses because vaccine shortages limited the availability of the fourth dose. This change was made because the ACIP recommends that if this vaccine is in short supply, or not available, the fourth dose of DTaP may be dropped. The performance reporting change was temporary and reporting for the fourth dose has now been implemented.

Varicella is the most recently introduced vaccine that has a measurable target. Varicella vaccination rates are rising with coverage at only 43 percent in 1998 and reaching 88 percent in 2005. CDC is close to meeting the 90 percent varicella vaccines coverage goal, and is continuing to increase coverage. CDC/HHS and the ACIP recently made policy changes for the use of varicella (chickenpox) vaccine to include a recommendation for routine two-dose varicella vaccination of children. This new recommendation is expected to further reduce the number of cases and outbreaks of varicella in the United States.

The prevention of pneumococcal infections with PCV is becoming more important because of problems with treatment due to antibiotic resistance. The ACIP added PCV to the 2001 Recommended Childhood Immunization Schedule. Accountability for performance targets will begin with CY 2006 data which will not be available until the next budget cycle. The vaccination coverage level for PCV in 2005 is 83 percent for three doses.

GOAL 3: INCREASE THE PROPORTION OF ADULTS WHO ARE VACCINATED ANNUALLY AGAINST INFLUENZA AND EVER VACCINATED AGAINST PNEUMOCOCCAL DISEASE.			
Measure	FY	Target	Result
1. Increase the rate of influenza and pneumococcal vaccination in persons 65 years of age and older to 90% by 2010.	2008	Influenza 85% Pneumococcal 80%	1/2010
	2007	Influenza 74%; pneumococcal 69%	1/2009
	2006	Influenza 74%; pneumococcal 69%	1/2008
	2005	Influenza 74%; pneumococcal 69%	Influenza 59.6% (Unmet) pneumococcal 56.2% (Unmet)
	2004	Influenza 74%; pneumococcal 69%	Influenza 65% (Unmet); pneumococcal 57% (Unmet)
	2003	Influenza 74%; pneumococcal 69%	Influenza 66% (Unmet); pneumococcal 56% (Unmet)
2. Increase the rate of influenza and pneumococcal vaccination among non-institutionalized high-risk adults aged 18 to 64 years to 60% by 2010.	2008	Influenza 40%; pneumococcal 35%	1/2010
	2007	Influenza 32%; pneumococcal 22%	1/2009
	2006	Influenza 32%; pneumococcal 22%	1/2008
	2005	Influenza 32%; pneumococcal 22%	Influenza 25.3% (Unmet) pneumococcal 22.6% (Met)
	2004	Influenza 32%; pneumococcal 22%	Influenza 35% (Met); pneumococcal 21% (Unmet)
	2003	Influenza 32%; pneumococcal 22%	Influenza 34% (Met); pneumococcal 21% (Unmet)
<b>Data Source:</b> National Health Interview Survey (NHIS).			
<b>Data Validation:</b> NHIS is a cross-sectional household interview survey. Households chosen for interviews are a probability sample representative of the target population. The annual response rate is more than 90 percent of eligible households in the sample. NHIS has three modules: 1) The basic module remains largely unchanged from year to year and allows for trend analysis. Data from more than one year can also be pooled to increase the sample size for analytic purposes. The basic module contains a family core, a sample adult core, and a child core through which data are collected on the family unit and from one randomly selected adult and child. 2) Periodic modules collect more detailed information on some of the topics included in the basic module. 3) Topical modules respond to new data needs as they arise. Data are collected through a personal household interview conducted by staff employed and trained by the U.S. Bureau of the Census according to procedures delineated by CDC. Data are reviewed and analyzed extensively to ensure their validity and reliability. The survey sample is designed to yield estimates that are representative and that have acceptably small variations. Before the actual survey, cognitive testing is performed by CDC's Questionnaire Design Research laboratory, and pretests are conducted in the field. Once collected, data are carefully edited, checked, and compared to data from earlier surveys and/or independent sources. Staff members calculate descriptive statistics and perform in-depth analyses, which result in feedback on the analytic usefulness of the data.			
<b>Cross Reference:</b> Measure 1 - HHS-1, HP-14.29a, 14.29b, 500-1; Measure 2 – HHS-1, HP-14.29c, 14.29d, 500-1			

#### Goal 3, Performance Measure 1:

During the past decade, vaccination coverage levels among older adults increased steadily as CDC implemented national strategies and promoted adult and adolescent immunization among healthcare providers and state and local governments. Influenza vaccination coverage levels among the elderly have increased from 30 percent in 1989 to 65 percent in 2004. However, data suggest that influenza vaccination levels may have reached a plateau, and in 2005 a decrease to coverage of 60 percent was observed. This is most likely related to unprecedented shortages of influenza vaccination in the 2004-2005 season and delays of influenza vaccinations in the 2005-2006 seasons.

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Despite recent vaccine availability issues, the increase in vaccination coverage began to slow before 2000. The plateau is not fully understood. Because large gaps remain between existing coverage levels and some of the targets for subsequent years, CDC has decided to maintain an influenza vaccination target of 74 percent for 2005, 2006 and 2007. There was an increase in vaccine supply to over 100 million doses in the 2006-2007 influenza season, and it is anticipated that supply will continue to increase in upcoming years. CDC and partners such as the National Influenza Vaccine Summit will continue to aggressively promote vaccination. Additionally, the FY 2007 and FY 2008 President's Budgets request funds to increase demand for influenza vaccine. Therefore, CDC has increased the target in 2008 to 85 percent coverage for influenza vaccination.

An increasing proportion of older adults also reported receipt of pneumococcal vaccination, from 15 percent in 1989 to 57 percent in 2004. Although the proportion of older adults receiving pneumococcal vaccine in 2005 (56.2%) remained consistent with the 2004 result, in neither year was the goal of 69% 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. Similar challenges apply to pneumococcal vaccination in adults as influenza vaccination. Because large gaps remain between existing coverage levels and some of the targets for subsequent years, CDC has decided to maintain the same targets for 2005, 2006 and 2007 for pneumococcal vaccination in this age group. However, due to an anticipated increase in aggressive vaccine promotion efforts, especially focused on influenza vaccination, but also including messages about pneumococcal vaccination, CDC has raised the 2008 goal to 80 percent.

**Goal 3, Performance Measure 2:**

The ACIP Recommended Adult Immunization Schedule recommends vaccination for influenza for adults at high risk of complications each year and pneumococcal vaccination for those persons at high risk. Current levels of coverage among adults vary widely among different age, risk, and racial and ethnic groups. High-risk adults aged 18 to 64 years may not have insurance coverage for influenza and pneumococcal vaccines, may make fewer visits for preventive care, and may not recognize they are recommended to receive influenza and pneumococcal vaccinations. Persons with high-risk conditions, such as heart disease and diabetes, remain at increased risk from these diseases. For this population of high risk adults 18 to 64 years of age, the pneumococcal vaccination goal of 22% has been met. However, as was noted for adults 65 years of age and older, a decrease in influenza vaccine coverage was seen in 2005 for the 18 to 64 year old population. It is likely that issues with vaccine availability, distribution, and recognition of priority group recommendation affected coverage status.

<b>GOAL 4: PROTECT AMERICANS FROM INFECTIOUS DISEASES INFLUENZA.</b>			
<b>Measure</b>	<b>FY</b>	<b>Target</b>	<b>Result</b>
1. By 2010, enhance preparedness for pandemic influenza by establishing influenza networks globally through bilateral cooperative agreements that are actively producing usable samples for testing as measured by geographic and population coverage.	2008	20 networks	12/2008
	2007	20 networks	12/2007
	2006	9 networks	13 (Exceeded)
	2005	9 networks	12 (Exceeded)
	2004	N/A	9 networks; 1 with 100% geographic coverage and 70% population coverage; 8 with 10-40% geographic coverage and 10-40% population coverage per country network.
	2003	Baseline	1 network; 60% geographic coverage; and, 60% population coverage per country network
<b>Data Source:</b> International bi-lateral cooperative agreement data and specimens received through the WHO Global Influenza Surveillance Network.			
<b>Data Validation:</b> CDC provides on-site technical assistance and review and analyzes the data for submittal of influenza samples and isolates for seasonal and pandemic influenza. Given that global coverage is necessary for both routine influenza virus monitoring and development of capacity to identify avian influenza for containment and response, ability to test of avian and other influenza and submit timely specimens is critical. Increasing geographic participation and enhancing capacity in more countries greatly increases the probability of detecting a case or cluster of H5N1.			
<b>Cross Reference:</b> HHS-4, 5, PART, 500-4			

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**Goal 4, Performance Measure 1:**

This measure tracks CDC's efforts to increase the number of influenza networks globally to enhance early detection of viruses with pandemic potential and improve vaccine decision-making. Early detection of pandemic viruses will benefit the international community by allowing the maximum lead time possible to develop pandemic vaccines, thus reducing morbidity and mortality globally. The accomplishment of this measure will also establish the influenza surveillance foundation necessary to conduct influenza burden studies, formulate vaccine policy, and reduce illness due to influenza through vaccination. Ideally, a network will be a nationwide system developed to collect virologic and epidemiologic data for influenza by establishing five or more sites with good distribution throughout the country. Each site will consist of a local laboratory and one or more clinics or hospitals for data collection. However, some flexibility of this definition may be needed based on geographic and resource considerations.

Currently, CDC supports 13 influenza surveillance networks globally through cooperative agreements. Support is provided through on-site training, the provision of technical assistance, and funding for equipment and supplies. As part of the overall plan to develop networks in Asia, key staff have been located in Asia with CDC assignments to Vietnam, Laos, Cambodia and the Western Pacific Office of WHO. CDC provides technical assistance and support for enhancing or developing influenza surveillance networks. In addition, CDC provides support and assistance to foreign governments for the establishment of surveillance networks in Cambodia, Korea, Indonesia, Pakistan, India, Philippines, Thailand, Mongolia, Malaysia, China, Vietnam, Kazakhstan and Pacific Public Health Surveillance Network (a consortium of seven countries and territories including Cook Islands, Fiji, Guam, Wallis and Futuna, Palau and Tonga). Finally, CDC provided critical support to partners in Department of Defense (DOD) at both Naval Medical Research Unit (NAMRU)-2 in Jakarta and NAMRU3 in Cairo. The collaborations enhance technical assistance regionally and improve sharing of international specimens. Expansion of the bilateral cooperative agreements in FY 2007 is planned with a focus on countries outside of Asia affected by avian influenza.

GOAL 5: PROTECT AMERICANS FROM INFECTIOUS DISEASES    PNEUMOCOCCAL DISEASE.			
Measure	FY	Target	Result
1. By 2010, reduce the rates of invasive pneumococcal disease in children under 5 years of age to 46 per 100,000 and in adults aged 65 years and older to 42 per 100,000. [O]		<i>Children under 5 years of age</i>	<i>Children under 5 years of age</i>
	2008	<b>46</b>	6/2009
	2007	47	6/2008
	2006	48	6/2007
	2005	50	21.3 (Exceeded)
		<i>Adults 65 years and older</i>	<i>Adults 65 years and older</i>
	2008	<b>42</b>	6/2009
	2007	45	6/2008
	2006	47	6/2007
	2005	55	38.8 (Met)
<b>Data Source:</b> The Active Bacterial Core surveillance (ABCs)/ Emerging Infections Program Network.			
<b>Data Validation:</b> The data are collected by 10 states through active contact with all clinical laboratories in population catchment areas; the data are sent to CDC monthly for review, editing and cleaning. States conduct audits for missed cases either monthly or in some cases bi-yearly. Pneumococcal isolates are collected and validated at three quality-controlled reference laboratories.			
<b>Cross Reference:</b> HHS-1, HP-14.5, PART			

**Goal 5, Performance Measure 1:**

Incidence of pneumococcal disease fell between 2001 and 2005. These data indicate that CDC is on track to reach disease reduction targets. Progress is aided by the introduction of the pneumococcal conjugate vaccine that was licensed for use in children in the U.S. in 2000. Vaccinating children has reduced disease in adults through reduced transmission. However, some challenges remain. Supplies of the conjugate vaccine were inadequate between 2001 and 2004. CDC has worked with the vaccine manufacturer, ACIP, and professional organizations to promote optimal and equitable use of vaccine during times of shortage. Vaccine supply is now adequate. However, a small increase in disease caused by strains not covered by the pneumococcal conjugate vaccine has been detected, and CDC is monitoring trends in these strains.

GOAL 6: IMPROVE VACCINE SAFETY SURVEILLANCE.			
Measure	FY	Target	Result
1. Improve capacity to conduct immunization safety studies by increasing the total population of managed care organization members from which the Vaccine Safety Datalink (VSD) data are derived annually to 13 million by 2010.	2008	<b>11 million</b>	6/2009
	2007	10 million	6/2008
	2006	10 million	6/2007
	2005	10 million	9.0 million (Unmet)
	2004	10 million	7.5 million (Unmet)
	2003	10 million	7.5 million (Unmet)
	2002	Baseline	7.5 million
<b>Data Source:</b> VSD			
<b>Data Validation:</b> Annual reports and other published information from the VSD-participating managed care organizations.			
<b>Cross Reference:</b> HHS-1, 2, 4, HP-14.31, 500-3			

**Goal 6, Performance Measure 1:**

The VSD is a collaborative effort involving CDC and several large managed care organizations (MCOs). The VSD was established primarily to assess immunization safety issues in the U.S. by conducting scientific studies utilizing a large-linked database (LLD) that incorporates administrative data sources at each MCO and also utilizing additional site resources such as medical charts. Each participating site gathers information regarding the vaccination and medical records of millions of children and adults. Collectively, the data from VSD studies are derived from participating MCOs that contain more than nine million members, of which the VSD project collects comprehensive medical information for more than 5.5 million people annually. The VSD enables population-based immunization and safety research studies to compare the incidence of health problems between vaccinated and unvaccinated people. The performance target for this goal was not met in FY 2005 because increasing populations in LLDs is contingent on cooperating entities, resources, and technologies. This performance measure reflects only one aspect of CDC's immunization safety surveillance; CDC's immunization safety activities are not limited to this one project.

### HIV/AIDS, VIRAL HEPATITIS, STD, AND TB PREVENTION

Efficiency Measure	FY	Target	Result
1. Decrease the amount of time in the review and oversight process for directly-funded Community-Based Organizations (CBOs), as reflected in the number of CDC programs for CBOs. [E]	2006	3 program announcements	3 current announcements (Met)
	2005	3 current announcements	3 current announcements (Met)
	2004	N/A	3 program announcements
	2003	Baseline	9 current program announcements
2. Improve the accuracy of the portrayal of the U.S. HIV epidemic in national reports by increasing the number of states using confidential name-based HIV reporting methods with level funding, thereby enabling CDC to report standardized HIV data from a larger number of jurisdictions. [E]	2008	<b>48</b>	12/2008
	2007	44	12/2007
	2006	42	46 (Exceeded)
	2005	Baseline	38
3. Reduce the amount of time it takes to award grantees' unobligated funds by meeting the Procurement and Grant Office's (PGO) key performance targets without increased funding. [E]	2008	<b>29</b>	10/2008
	2007	35	10/2007
	2006	40	29 (Exceeded)
	2005	Baseline	52 days
<b>Data Source:</b> <u>Measures 1 and 2</u> - HIV/AIDS Reporting System (HARS) is used to collect state HIV and AIDS data. Data for measure 2 reflect end of calendar year performance. <u>Measure 3</u> - The data source for this measure is PGO's annual KPI tracking report.			
<b>Data Validation:</b> CDC conducts validation and evaluation studies of data systems which track AIDS deaths and HIV diagnosis to determine the quality of data generated by them.			
<b>Cross Reference:</b> HHS-8			

#### **Efficiency Measure 1:**

In FY 2004, CDC consolidated six program announcements for CBOs into one program announcement. The consolidation decreased the administrative work at CDC required to develop, publish, compete, review and award six different program announcements. This consolidation also provided CDC with the opportunity to improve oversight of grantees by reducing the number of different grant requirements which project officers are expected to know. Finally, the new program announcement included a set of core performance indicators to monitor and evaluate grantee performance.

The review process used to evaluate applications involves convening special emphasis panels, obtaining subject matter experts, conducting pre-decisional site visits and budget negotiations, and developing technical reports for each program announcement. By consolidating the six program announcements, CDC was able to streamline the review and oversight process, thereby decreasing staff time and cost for all of these functions.

This efficiency measure was a temporary measure that was used to demonstrate the efficiency of CDC staff in developing, publishing, and completing the review and award of funds for one comprehensive program announcement for directly funded CBOs compared with six different announcements. Now that the data for FY 2006 have been reported, the measure is retired and will not be reflected in future performance detail.

#### **Efficiency Measure 2:**

As available treatments prolong the lives of those infected with HIV and slow the progression to AIDS, AIDS data are increasingly insufficient to describe the national epidemic. Accurate, reliable, and comparable HIV data are needed from all states to describe the epidemic nationally. Although all states have implemented HIV reporting, it occurs via a number of methods. As of December 2006, 46 states and five territories and Washington, D.C. have adopted confidential, name-based reporting and four states implement code-based systems. Except for HIV, all other reported infectious diseases, including AIDS, are routinely reported to states using name-based reporting systems. Personal identifiers are removed from this data prior to submission to CDC. Because of the lack of standard methods for reporting diagnoses and the potential for duplication of cases arising from these multiple methods, HIV

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data are not sufficiently accurate and reliable to provide data on HIV prevalence nationwide. CDC's policy is to accept HIV infection and AIDS case surveillance data only from areas conducting confidential name-based reporting because this reporting has been shown to routinely achieve high levels of accuracy and reliability. Further, only confidential name-based HIV reporting integrated with AIDS surveillance data can be used by states to remove duplicate cases reported to CDC's national surveillance database. For these reasons, in July 2005, CDC recommended that states conduct HIV reporting using the same name-based approach currently used for AIDS surveillance nationwide. This measure will monitor changes from coded systems to confidential, name-based reporting. Such changes will increase the proportion of HIV cases that are included in the national database, thereby providing a more accurate picture of the epidemic nationwide and enabling better targeting of federal HIV resources.

**Efficiency Measure 3:**

CDC funds both non-research and research funding opportunity announcements for HIV (Domestic), STDs and TB. Unobligated funds (i.e. carryover) are common for grantees due to various circumstances such as: unspent personnel funds realized while grantees' are advertising jobs; unspent contractual funds when grantees publish program announcements for subcontractors; savings realized in purchases of equipment or services; and in-kind resources acquired by grantees from donations to cover approved expenses.

For FY 2005, HIV (Domestic), STD and TB programs carryover requests averaged 52 days for processing. In order to meet PGO's key performance indicator (KPI) target, CDC will improve the average time to process request to award by meeting PGO's KPI of 29 days for carryover requests as the end target.

This is an important efficiency for CDC for two reasons. First, the unobligated funds are reobligated to program, mission-direct grantee activities and are needed in a timely fashion. Second, this efficiency measure will decrease the amount of staff time spent on administrative activities.

**OVERARCHING HIV/AIDS PREVENTION**

Twenty-five years into the epidemic, HIV is still a fatal infection for which there is no cure. Available treatments have dramatically improved the lives of those infected. However, treatments must be taken over the course of a lifetime, have serious side-effects, and are costly. Further, one-quarter of those who are infected do not know of their infection and do not benefit from treatment. The chief goal of CDC's HIV efforts is to reduce the number of new infections in the U.S.

<b>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.</b>			
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<b>Measure</b>	<b>FY</b>	<b>Target</b>	<b>Result</b>
1. Reduce the rate of HIV infections diagnosed each year among people under 25 years of age. <sup>1</sup> [O]	2008	8.6/100,000 in 33 states	11/2009
	2007	<4000 cases in 30 areas	11/2008
	2006	Overall: 2,420 reported cases in 30 areas	11/2007
	2005	Overall: 1,800 reported cases in 25 states	2,700 in 25 states; (Unmet) 3,605 in 30 areas 7.4/100,000 in 33 states
	2004	Overall: 1,900 reported cases in 25 states	2,606 in 25 states; (Unmet) 3,465 in 30 areas (Unmet);
	2003	N/A	2,286 in 25 states; 3,134 in 30 areas; 6.9/100,000 in 33 states
	2002	N/A	N/A
2. Decrease the number of perinatally acquired AIDS cases, from the 1998 base of 247 cases. [O]	2008	<b>&lt;100 cases</b>	11/2009
	2007	<100 cases	11/2008
	2006	<100 cases	11/2007
	2005	<100 cases	58 (Exceeded)
	2004	<100 cases	48 (Exceeded)
	2003	<139 cases	69 (Exceeded)

**GOAL 1: BY 2010, REDUCE BY 25% THE NUMBER OF NEW HIV INFECTIONS IN THE U. S., AS MEASURED BY A  
REDUCTION IN THE NUMBER OF HIV INFECTIONS DIAGNOSED EACH YEAR AMONG PEOPLE UNDER 25 YEARS OF  
AGE, FROM 2,100 IN 2000 TO APPROXIMATELY 1,600 IN 2010.**

**Data Source:** HIV/AIDS Reporting System (HARS).

**Data Validation:** HIV data collection systems vary between areas (e.g., name-based code, coded identifier, name-to-code data collection systems). CDC recommends that all states and territories adopt confidential name-based HIV surveillance systems. As of December 2006, 46 states, the District of Columbia and five territories use confidential name-based HIV surveillance, while two states use name-to-code-based systems, and five states and the District of Columbia use code-based methods. The 25 states with mature, stable HIV surveillance systems at baseline are: Alabama, Arizona, Arkansas, Colorado, Idaho, Indiana, Louisiana, Michigan, Minnesota, Mississippi, Missouri, Nevada, New Jersey, North Carolina, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Utah, Virginia, West Virginia, Wisconsin, and Wyoming. The 30 area comparison group includes the 25 states plus Florida, Iowa, Nebraska, New Mexico, and the U.S. Virgin Islands. The period of time between a diagnosis of HIV or AIDS and the arrival of a case report at CDC is called the "reporting delay". The 33 states included in targets for rates include the 29 states listed above and Alaska, Kansas, New York, and Texas. Targets for 2008 have been converted to rates; previous targets were set based on the number of cases reported. Population data come from the Bureau of Census and are limited to the population of persons under 25 years of age in the 33 states. The period of time between a diagnosis of HIV or AIDS and the arrival of a case report at CDC is called the "reporting delay". In order to provide the best estimates of recent trends, HIV and AIDS surveillance data are analyzed by date of diagnosis and are statistically adjusted for reporting delays and incomplete information on some cases. CDC requires a minimum of 12 months after the end of a calendar year to provide accurate estimates of trends for that year.

**Cross Reference:** Measure 1 – HHS-1, PART, PAR, 500-6; Measure 2 - HHS-1, HP-13.17, PAR, 500-6

<sup>1</sup>This measure was first reported in FY 2004 and therefore, targets begin in FY 2004. However, actual performance is shown for previous years because the data was available, even though it was not reported in the form of a measure.

**Goal 1, Performance Measure 1:**

The rate of HIV infection diagnoses among persons under 25 years of age each year is the best data available to monitor new HIV infections on an annual basis. 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, it enables CDC to examine yearly trends in reported cases by risk, demographic, and geographic variables. The data 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 name-based HIV reporting requirements. Data for 2008 will be reported as rates from 33 states with long-standing HIV reporting. Rates provide a more accurate methodology of measuring program performance over time, as they provide a percentage for the population affected. Targets for previous years were set based on the number of cases reported. While annual data on HIV incidence are not yet available, CDC has estimated HIV incidence in the past. After dramatic reductions from a peak of 150,000 infections per year in the mid-1980's, annual HIV incidence is hypothesized to be level in the U.S. However, recent outbreaks of syphilis among men who have sex with men have raised concerns that HIV incidence may be rising rather than decreasing. CDC is working to reduce incidence in this and other high risk groups. Recent initiatives to greatly expand HIV testing are expected to have a substantial impact on the proportion of infected persons who are diagnosed. Therefore, in the short term, the number of cases diagnosed and reported to CDC is expected to rise. The FY 2007 and FY 2008 targets have been adjusted accordingly. In the long-term, helping people learn of their infection and providing them prevention services is expected to decrease the number of new infections.

**Goal 1, Performance Measure 2:**

Surveillance data published through 2005 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 likely delays the 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*

<b>GOAL 2: DECREASE THE NUMBER OF PERSONS AT HIGH RISK FOR ACQUIRING OR TRANSMITTING HIV INFECTION.</b>			
<b>Measure</b>	<b>FY</b>	<b>Target</b>	<b>Result</b>
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]	2008	<14%	11/2009
	2007	<11%	11/2008
	2006	<11%	Not available (Unmet)
	2005	<10%	Not available (Unmet)
	2004	<10%	13.4% (median) (Unmet)
	2003	N/A	17.0% (median)

**Data Source:** CDC Supplement to the HIV/AIDS Surveillance (SHAS), CDC Medical Monitoring Project (MMP) (Beginning in 2007).

**Data Validation:** CDC conducts validation and evaluation studies of data systems which track AIDS deaths and HIV diagnosis to determine the quality of data generated by them. The SHAS project was discontinued in June 2004. Data for 2004 reflect six months of data.

**Cross Reference:** HHS-1, 500-6

**Goal 2, Performance Measure 1:**

Because every new HIV infection is the result of transmission from an infected person, encouraging infected persons to adopt safe behaviors is one of the highest priorities of HIV prevention. Helping those who are infected to adopt safer behaviors is a key strategy of CDC's HIV initiative, Advancing HIV Prevention (AHP). In 2004, CDC asked state grantees to prioritize interventions with those who are HIV-infected, and included prevention with infected persons as a key component of their new directly-funded CBO program. Targets and actual performance estimates represent the median figure from 16 participating areas. The survey used until 2004 for this measure was discontinued that year. Beginning in 2007, data for this measure will be collected through the new Medical Monitoring Project (MMP), which is to collect data beginning in 2007. While in transition to the MMP, the national survey was not conducted in 2005 or in 2006. Therefore, data will not be available for 2005 and 2006.

<b>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%).</b>			
<b>Measure</b>	<b>FY</b>	<b>Target</b>	<b>Result</b>
1. Among persons with HIV infection, increase the proportion diagnosed before progression to AIDS. [O]	2008	79%	11/2009
	2007	79%	11/2008
	2006	79%	11/2007
	2005	80%	77% (Unmet)
	2004	80%	78% (Unmet)
	2003	N/A	78% Data are from 30 areas with stable HIV reporting systems
2. Increase the percentage of HIV-positive tests with post-test counseling sessions reported from CDC funded test sites. [O]	2008	75%	10/2010
	2007	75%	10/2009
	2006	75%	10/2008
	2005	80%	10/2007
	2004	80%	71% (Unmet)
	2003	75%	71% (Unmet)

**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%).**

**Data Source:** CDC HIV/AIDS Reporting System, CDC HIV Counseling and Testing System (CTS).

**Data Validation:** CDC conducts validation and evaluation studies of data systems which track AIDS deaths and HIV diagnosis to determine the quality of data generated by them. As of December 2006, 46 states, the District of Columbia and five territories conduct confidential, name-based reporting for persons diagnosed with HIV who have not developed AIDS. CDC recommends that all states and territories adopt confidential name-based HIV surveillance. The 30 areas in measure 1 are Alabama, Arizona, Arkansas, Colorado, Florida, Idaho, Indiana, Iowa, Louisiana, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, U.S. Virgin Islands, Utah, Virginia, West Virginia, Wisconsin, and Wyoming.

**Cross Reference:** Measure 1 – HHS-1, HP-13.15, PART, 500-6; Measure 2 – HHS-1, 500-6

**Goal 3:**

As deaths due to AIDS have decreased and the rate of new infections has remained stable, the number of persons living with HIV/AIDS has increased. If incidence does not decrease, the number of persons living with HIV and AIDS is expected to continue to increase slightly each year. Further, of the estimated 1,039,000 to 1,185,000 persons infected with HIV in the U.S., one-fourth are unaware of their infection. Reducing the incidence of both new infections and HIV associated morbidity and mortality will require earlier testing and improved access to prevention and care services for persons with HIV. Research shows that persons who are aware of their infection are more likely to adopt behaviors to protect themselves and their partners. Thus, promoting knowledge of serostatus among those who are infected is essential in preventing new infections. In 2006, as part of the President's initiative to Continue the Fight Against HIV/AIDS in America, CDC issued revised recommendations for HIV testing for adults and adolescents, aimed at increasing the proportion of persons who are aware of their infection. The recommendations call for voluntary, routine testing of all adults and adolescents, without regard to expressed risk and simplify the consent process. CDC has begun to plan for other key parts of the initiative, including programs to directly provide testing to jurisdictions with the highest numbers of new cases.

**Goal 3, Performance Measure 1:**

This measure is an indicator of the percentage of persons who learn of their infection before the development of an AIDS-defining condition. Compared with early testers, late testers are more likely to be young, black or Hispanic and to receive HIV testing because of illness. Early testers are more likely to seek testing because of self-perceived risk. The percentage of persons diagnosed with HIV and AIDS simultaneously should decrease over time if a greater proportion of HIV-infected persons find out their HIV status earlier. Activities related to these measures include efforts to increase knowledge of HIV status through voluntary counseling and testing, and to encourage routine testing for HIV in health care settings.

**Goal 3, Performance Measure 2:**

Each year, approximately two million publicly funded HIV tests are reported from over 11,000 sites, each with varying rates of clients returning for their test results. There was a reported increase from 69.3 percent in 2000 to 71 percent in 2004 in the percentage of HIV-positive test results from CDC-funded sites with post test counseling reported. CDC is working with all grantees to continue improving the return rates for HIV-positive test results. HIV rapid tests now allow return of preliminary HIV test results "while you wait" increasing the number of people who receive their preliminary results. HIV positive test results still require confirmatory testing, with results shared at post-test counseling sessions. In FY 2002, two jurisdictions reported incomplete data and were not included in the overall calculation.

**GOAL 4: BY 2010, INCREASE TO AT LEAST 80% THE PROPORTION OF HIV INFECTED PEOPLE WHO ARE LINKED TO APPROPRIATE PREVENTION, CARE, AND TREATMENT SERVICES, AS MEASURED BY THOSE WHO REPORT HAVING RECEIVED SOME FORM OF MEDICAL CARE WITHIN 3 MONTHS OF THEIR HIV DIAGNOSIS (2001 BASELINE: 79%).**

Measure	FY	Target	Result
1. Increase the proportion of HIV-infected people who received some form of medical care within 3 months of HIV diagnosis. [O]  (Data are from interviews taken from a sample of persons in 16 areas.)	2008	80%	11/2009
	2007	80%	11/2008
	2006	80%	Not available (Unmet)
	2005	80%	Not available (Unmet)
	2004	80%	86.1% (Exceeded)
	2003	N/A	83.3%

**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%).**

**Data Source:** CDC SHAS, MMP (Beginning in 2007).

**Data Validation:** CDC conducts validation and evaluation studies of data systems which track AIDS deaths and HIV diagnosis to determine the quality of data generated by them. The SHAS project was discontinued in June 2004. Data for 2004 reflect six months of data.

**Cross Reference:** HHS-1, PART, 500-6

**Goal 4, Performance Measure 1:**

This measure reflects linkage to care after initial diagnosis. A physician should evaluate an HIV-infected person soon after receiving the initial positive results. However, many persons are not evaluated because of fear or lack of access to medical care. The data through 2004 for this measure were collected through interviews with HIV-infected persons in 16 areas. That survey has been discontinued. Beginning in 2007, data will be collected using the new MMP. While in transition to the MMP, the national survey was not conducted in 2005 or in 2006. Therefore, data will not be available for 2005 and 2006.

**GOAL 5: STRENGTHEN THE CAPACITY NATIONWIDE TO MONITOR THE EPIDEMIC; DEVELOP AND IMPLEMENT EFFECTIVE HIV PREVENTION INTERVENTIONS; AND EVALUATE PREVENTION PROGRAMS.**

Measure	FY	Target	Result
1. Increase the number of states and the District of Columbia that conduct HIV case reporting in adults and adolescents.	2008	50 states and D.C.	10/2008
	2007	50 states and D.C.	10/2007
	2006	50 states and D.C.	50 states and DC; 46 states and DC use confidential, name-based reporting (Met)
	2005	50 states and D.C.	50 states and DC; 38 use confidential, name-based reporting (Met)
	2004	50 states and D.C.	50 states and DC; 38 use confidential, name-based reporting (Met)
	2003	50 states	49 states and D.C.; 34 use confidential, name-based reporting (Unmet)

**Data Source:** CDC HIV/AIDS Reporting System (HARS).

**Data Validation:** CDC conducts validation and evaluation studies of data systems which track AIDS deaths and HIV diagnosis to determine the quality of data generated by them.

**Cross Reference:** HHS-1, 500-6

**Goal 5, Performance Measure 1:**

Historically, new AIDS cases (AIDS incidence) were the basis for assessing needs for prevention and treatment programs. However, potent new antiretroviral therapies are delaying 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. Currently, all states have implemented some form of HIV reporting. HIV reporting in the U.S. is conducted using one of three methods: 1) name-based; 2) code; and, 3) name-to-code. As of December 2006, 46 states, the District of Columbia, and five territories use confidential name-based reporting systems for HIV case surveillance. CDC recommends that all states use confidential name-based methods for HIV case surveillance and is working with states to implement and improve HIV reporting and is implementing methods to estimate HIV incidence nationally.

**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

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professionals are prepared to provide optimal STD treatment, care, and prevention services; and, 4) building national partnerships for STD prevention to educate health professionals, the public, and policymakers about the importance of STD prevention and the impact of STDs on the health of Americans, particularly women and infants, adolescents, and minority populations; and 5) providing financial, direct personnel, and technical assistance to state and local health departments to deliver clinical and prevention services.

Two foci are syphilis elimination and infertility prevention. CDC also supports special surveillance studies for human papillomavirus (HPV) and herpes simplex 2 (HSV-2); supports epidemiologic, behavioral, laboratory and health services research on a variety of STDs; provides program support, training and health communications for national STD prevention programs; and develops recommendations for HPV vaccines and implementation issues pertinent to such vaccines.

<b>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.</b>			
<b>Measure</b>	<b>FY</b>	<b>Target</b>	<b>Result</b>
1. Reduce the prevalence of chlamydia among women under age 25, in publicly funded family planning clinics. [O]	2005	<5% median	6.3% (Unmet)
	2004	<5% median	6.3% (Unmet)
	2003	<5% median	5.9% (Unmet)
	2002	<5% median	5.6% (Unmet)
2. Reduce the incidence of gonorrhea in women aged 15 to 44. [O]	2005	<250/100,000 women	276/100,000 women (Unmet)
	2004	<250/100,000 women	278/100,000 women (Unmet)
	2003	<250/100,000 women	268/100,000 (Unmet)
	2002	<250/100,000 women	279/100,000 (Unmet)
<b>Data Source:</b> CDC STD Morbidity Surveillance System, CDC Infertility Prevention Program (IPP), the U.S. Department of Labor National Job Training Program, CDC National Center for Health Statistics (NCHS), and National Diagnostic and Therapeutic Index by IMS America, Ltd.			
<b>Data Validation:</b> Data in the STD Morbidity Surveillance System undergo verification and validation procedures including reports back to project areas concerning quarterly and yearly data, trend information, and percentage unknowns for demographic and clinical fields, edit checks and updates, as well as regular communications via fax, phone, and email with project staff. Pelvic Inflammatory Disease (PID) hospitalization data are collected by the NCHS. Data for PID initial visits to physicians are collected through the National Diagnostic and Therapeutic Index by IMS America, Ltd. Additional feedback is provided to project areas via annual publications and reports.			
<b>Cross Reference:</b> <u>Measure 1</u> - HHS-1, HP-25.1a, 500-1; <u>Measure 2</u> - HHS-1, HP-25.2, 500-1; <u>Measure 3</u> - HHS-1, 500-1; <u>Measure 4</u> - HHS-1, HP-25.6, 500-1			

#### **Goal 6, Performance Measure 1:**

In 2005, the median chlamydia test positivity among 15-24 year-old women who were screened during visits to selected family planning clinics in all states and outlying areas was 6.3 percent (range: 3.0 percent to 20.3 percent). However, in nearly all states, chlamydia positivity was greater than the Healthy People 2010 objective of three percent. The source for the data is the CDC IPP. The continued expansion of screening programs to populations with higher prevalence of disease, use of more sensitive diagnostic tests, and high rates of reinfection from untreated sex partners likely contributed to the increase in overall median positivity. This measure has been revised for FY 2006 (see below).

#### **Goal 6, Performance Measure 2:**

The U.S. experienced a 74.3 percent decline in the reported rate of gonorrhea from 1975 to 1997. After a small increase in 1998, the gonorrhea rate has decreased slightly since 1998.

Among women aged 15 to 44, the 2005 gonorrhea rate was 276 per 100,000 population, which is above the target rate of 250. Although increased screening (usually associated with simultaneous testing for chlamydial infection), use of more sensitive diagnostic tests, and improved reporting may account for a portion of the recent increase, true increases in disease in some populations and geographic areas also appear to have occurred. The source for these data is the STD Morbidity Surveillance System, CDC. This measure has been revised for FY 2006 (see below).

GOAL 7: REDUCE THE INCIDENCE OF PRIMARY AND SECONDARY SYPHILIS.			
Measure	FY	Target	Result
1. Increase the percentage of U.S. counties with an incidence of P&S syphilis in the general population of 4/100,000. [O]	2005	>95% of counties	93.8% (Unmet)
	2004	>95% of counties	94.5% (Unmet)
	2003	>95% of counties	95% (Met)
	2002	>92% of counties	94% (Exceeded)
2. Reduce the racial disparity (reported ratio is black:white). [O]	2005	11:1	5.4:1 (Exceeded)
	2004	13:1	5.6:1 (Exceeded)
	2003	15% to 14:1	38% reduction to 5:1 (Exceeded)
	2002	15% to 17:1	50% reduction to 8:1 (Exceeded)
<b>Data Source:</b> STD Morbidity Surveillance System, CDC.			
<b>Data Validation:</b> Data in the STD Morbidity Surveillance System undergo verification and validation procedures including reports back to project areas concerning quarterly and yearly data, trend information, and percentage unknowns for demographic and clinical fields, edit checks and updates, as well as regular communications via fax, phone, and email with project staff.			
<b>Cross Reference:</b> Measure 1 - HHS-1, HP-25.3; Measure 2 - HHS-3, HP-25.3, 500-1			

#### Goal 7, Performance Measure 1:

The rate of primary and secondary (P&S) syphilis in the U.S. declined by 89.7 percent from 1990 through 2000. In 2005, 93.8 percent of U.S. counties had an incidence of P&S syphilis in the population equal or below four per 100,000. Recent outbreaks of syphilis among men who have sex with men (MSM) have been reported, reflecting an increase in risky sexual behavior in this population and negatively affecting the significant reductions in P&S syphilis in the past decade. The rate of P&S syphilis increased slightly in 2005 from 2.7 in 2004 to 3.0 per 100,000 population. This increase was observed primarily in men (4.7 to 5.1 per 100,000 population), though syphilis rates in women increased slightly between 2004 and 2005 (0.8 to 0.9 per 100,000 population). Now that the data for FY 2005 have been reported, the measure is retired and will not be reflected in future performance detail.

#### Goal 7, Performance Measure 2:

P&S syphilis remains an example of racial disparity in health, with 2005 rates among African Americans 5.4 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 (5.4:1) is still much higher than that for other health outcomes: including infant mortality (2.5:1), and deaths attributable to heart disease (1.3:1). Communities burdened by poverty, racism, unemployment, low rates of health insurance, and inadequate access to healthcare are often disproportionately affected by syphilis. CDC aims to continue reducing this racial disparity. This measure has been revised for FY 2006 (see below).

GOAL 8: REDUCE THE INCIDENCE OF CONGENITAL SYPHILIS.			
Measure	FY	Target	Result
1. Reduce the incidence of congenital syphilis per 100,000 births. [O]	2005	<12	8.0 (Exceeded)
	2004	<12	8.8 (Exceeded)
	2003	<12	10.3 (Exceeded)
	2002	<12	11.4 (Exceeded)
<b>Data Source:</b> STD Morbidity Surveillance System, CDC			
<b>Data Validation:</b> Data in the STD Morbidity Surveillance System undergo verification and validation procedures including reports back to project areas concerning quarterly and yearly data, trend information, and percentage unknowns for demographic and clinical fields, edit checks and updates, as well as regular communications via fax, phone, and email with project staff.			
<b>Cross Reference:</b> HHS-1, HP-25.9, 500-1			

**Goal 8, Performance Measure 1:**

The continuing decrease in the rate of congenital syphilis likely reflects the substantial reduction in the rate of P&S syphilis among women that has occurred in the last decade. Between 1995 and 2005, the average yearly percentage decrease in the congenital syphilis rate was 15.8 percent. The average yearly percentage decrease in the rate of P&S syphilis reported among women for the years 1995 through 2005 was 16.0 percent. This measure has been revised for FY 2006 (see below).

Insufficient syphilis serologic testing and treatment of women for syphilis during pregnancy remains the major reason congenital syphilis persists in the U.S. When a woman has a syphilis infection during pregnancy, she may transmit the infection to the fetus in utero. This may result in fetal death or an infant born with physical and mental developmental disabilities. Most cases of congenital syphilis are easily preventable if women are screened for syphilis and treated early during prenatal care. Each positive test in a child is considered a medical emergency with immediate health services follow-up. The absence of testing is often related to complete lack of, or late initiation of, prenatal care. Between 2004 and 2005, the overall rate of congenital syphilis decreased 12.1 percent in the U.S., from 9.1 to 8.0 cases per 100,000 live births.

**Goals 9 and 10:**

During the FY 2006 (CY 2004) 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 revised its goals for STD prevention. CDC will track the following goals and measures (Goals 9 and 10) and will no longer report on goals six through eight, after reporting for their FY 2005 targets has been completed.

<b>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).</b>			
<b>Measure</b>	<b>FY</b>	<b>Target</b>	<b>Result</b>
1. Reduce the prevalence of chlamydia among high-risk women under age 25 by 15%. [O]	2008	<10%	10/2009
	2007	9.3%	10/2008
	2006	9.3%	10/2007
	2002	Baseline	10.1%
2. Reduce the prevalence of chlamydia among women under age 25, in publicly funded family planning clinics by 15%. [O]	2008	<7%	10/2009
	2007	6.3%	10/2008
	2006	6.3%	10/2007
	2002	Baseline	5.6%
3. Reduce the incidence of gonorrhea in women aged 15 to 44 by 15%. [O]	2008	<280/100,000	10/2009
	2007	278/100,000	10/2008
	2006	278/100,000	10/2007
	2002	Baseline	279/100,000
<b>Data Source:</b> The source for these data is the U.S. Department of Labor; U.S. Job Corps, IPP, CDC, and the STD Morbidity Surveillance System, CDC. 2002 data from the U.S. Job Corps are from 28 states and Puerto Rico. 2004 data are from 38 states and Puerto Rico.			
<b>Data Validation:</b> Data from STD Morbidity Surveillance System undergo verification and validation procedures including reports back to project areas concerning quarterly and yearly data, trend information, and percentage unknowns for demographic and clinical fields, edit checks and updates, as well as regular communications via fax, phone, and email with project staff. Data for PID initial visits to physicians are collected through the National Diagnostic and Therapeutic Index by IMS America, Ltd. Additional feedback is provided to project areas via annual publications and reports.			
<b>Cross Reference:</b> <u>Measure 1</u> - HHS-1, PART, 500-1; <u>Measure 2</u> - HHS-1, HP-25.1a, 500-1; <u>Measure 3</u> - HHS-1, HP-25.2, 500-1			

**Goal 9, Performance Measure 1:**

Data on the prevalence of chlamydial infection in defined populations have been useful to monitor disease burden and guide screening programs. For example, CDC monitors trends in prevalence among women enrolled in the U.S. Department of Labor National Job Training Program for economically disadvantaged women aged 16 to 24 who enter this program. Increased efforts to promote screening by medical practitioners are needed to achieve reductions in chlamydia in this and other populations. The FY 2008 target reflects what is achievable given current trends.

**Goal 9, Performance Measure 2:**

Chlamydia remains widespread and is a significant threat to women's health. Because chlamydia is usually asymptomatic and is most common among young women, CDC recommends annual chlamydia screening for sexually active women age 25 and under. This measure reflects chlamydia prevalence in programs receiving support from CDC. The FY 2008 target reflects what is achievable given current trends.

**Goal 9, Performance Measure 3:**

Chlamydia and gonorrhea are the most important preventable causes of infertility and potentially fatal tubal pregnancy. CDC conducts screening for chlamydia and gonorrhea to prevent PID from untreated infection. If not adequately treated, up to 40 percent of women infected with chlamydia or gonorrhea will develop infection (i.e., PID) in the uterus or fallopian tubes. PID can lead to chronic pelvic pain, infertility and ectopic pregnancy. These measures reflect the importance of reducing this adverse health outcome. The FY 2008 target reflects what is achievable given current trends.

<b>GOAL 10: REDUCE THE INCIDENCE OF PRIMARY AND SECONDARY (P&amp;S) SYPHILIS BY 12% AND CONGENITAL SYPHILIS BY 62%.</b>			
<b>Measure</b>	<b>FY</b>	<b>Target</b>	<b>Result</b>
1a) Reduce the incidence of P&S syphilis in men per 100,000 population by 7%. [O]	2008	<5/100,000	10/2009
	2007	4.5/100,000	10/2008
	2006	Establish Baseline <sup>1</sup>	10/2007
1b) Reduce the incidence of P&S syphilis in women per 100,000 population by 65%. [O]	2008	<1.0/100,000	10/2009
	2007	0.8/100,000	10/2008
	2006	0.58/100,000	10/2007
	2002	Baseline	1.1/100,000
2. Reduce the incidence of congenital syphilis per 100,000 live births. [O]	2008	<10/100,000	10/2009
	2007	8.8/100,000	10/2008
	2006	8.8/100,000	10/2007
	2002	Baseline	11.4/100,000
3. Reduce the racial disparity of P&S syphilis by 63% (reported ratio is black:white). [O]	2008	≤ 7 to 1	10/2009
	2007	5.6 to 1	10/2008
	2006	5.6 to 1	10/2007
	2002	Baseline	8.1 to 1
<b>Data Source:</b> STD Morbidity Surveillance System, CDC.			
<b>Data Validation:</b> Data from STD Morbidity Surveillance System undergo verification and validation procedures including reports back to project areas concerning quarterly and yearly data, trend information, and percentage unknowns for demographic and clinical fields, edit checks and updates, as well as regular communications via fax, phone, and email with project staff.			
<b>Cross Reference:</b> <u>Measure 1a</u> – HHS-1, PART, 500-1; <u>Measure 1b</u> – HHS-1, PART, HP-25.3, 500-1; <u>Measure 2</u> – HHS-1, HP-25.9, 500-1; <u>Measure 3</u> - HHS-3, HP-25.3, 500-1			

<sup>1</sup> In FY 2002, the incidence of P&S syphilis in men was 3.8 per 100,000 (initial FY 2002 baseline). However, because of an outbreak of syphilis among men who have sex with men that occurred after 2002, CDC will report a new baseline for FY 2006. The overall goal for 2010 is a decrease in incidence of 12 percent as compared to the FY 2006 baseline.

**Goal 10:**

Syphilis, a genital ulcerative disease, is highly infectious, but easily curable in its early (primary and secondary – P&S) stages. If untreated, it can lead to long-term complications including nerve, cardiovascular and organ damage and even death. Congenital syphilis (transmission from mother to child) can cause stillbirth, death soon after birth, physical deformity and neurological complications in children who survive. Syphilis also facilitates the spread of HIV, increasing transmission of the virus at least two-to-five fold.

**Goal 10, Performance Measure 1a:**

Although the rate of P&S syphilis in the U.S. declined by 89.7 percent during 1990-2000, the rate of P&S syphilis remained unchanged between 2000 and 2001, and increased annually since 2002. Overall increases in rates during 2001-2004 were observed only among men, but in 2005, there was also a slight increase in the rate among women. 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.

**Goal 10, Performance Measure 1b:**

Syphilis rates in women declined with the implementation of the Syphilis Elimination Plan (from 2.0/100,000 in 1999 to 0.9/100,000 in 2005). CDC will continue to strive to decrease syphilis cases among women, both to protect the health of women and to prevent congenital syphilis. Untreated early syphilis during pregnancy results in perinatal death in up to 40 percent of cases, and, if acquired during the four years preceding pregnancy, may lead to infection of the fetus in over 70 percent of cases. The FY 2008 target reflects what is achievable given current trends.

**Goal 10, Performance Measure 2:**

When a woman has a syphilis infection during pregnancy, she may transmit the infection to the fetus in *utero*. This often results in fetal death or an infant born with physical and mental developmental disabilities. Most cases of congenital syphilis are easily preventable if women are screened for syphilis and treated early during prenatal care. The FY 2008 target reflects what is achievable given current trends.

**Goal 10, Performance Measure 3:**

Syphilis remains an example of racial disparity in health, with 2005 rates among African Americans 5.4 times those among white Americans, down from a 64-fold differential at the beginning of the last decade. The racial disparity (5.4:1) is higher compared to many other health outcomes including infant mortality (2.5:1), and deaths attributable to heart disease (1.3:1). Communities burdened by poverty, racism, unemployment, low rates of health insurance, and inadequate access to healthcare are often disproportionately affected by syphilis. The FY 2008 target reflects what is achievable given current trends.

**TUBERCULOSIS**

<b>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.</b>			
<b>Measure</b>	<b>FY</b>	<b>Target</b>	<b>Result</b>
1. Decrease the number of persons with TB among US-born persons, foreign-born persons, and overall (per 100,000 population). [O]	2008	<b>US-born 2.6 ; Foreign-born 22.8; Overall 4.9</b>	9/2009
	2007	US-born 1.9 ; Foreign-born 21.2; Overall 3.9	9/2008
	2006	US-born 1.9 ; Foreign-born 21.2; Overall 3.9	9/2007
	2004	Baseline	US born: 2.6; Foreign-born: 22.8; Overall: 4.9
2. Increase the percentage of TB patients who complete a course of curative TB treatment within 12 months of initiation of treatment (some patients require more than 12 months). <sup>1</sup> [O]	2008	>85%	9/2011
	2007	88%	9/2010
	2006	88%	9/2009
	2005	88%	9/2008
	2004	88%	9/2007

**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.**

<b>Measure</b>	<b>FY</b>	<b>Target</b>	<b>Result</b>
	2003	88%	81.5% (Unmet)
	2002	88%	80.9% (Unmet)
	1999	Baseline	67.6%
3. Increase the percentage of TB patients with initial positive cultures who also have drug susceptibility results. [O]	2008	95%	9/2009
	2007	95%	9/2008
	2006	95%	9/2007
	2005	95%	94.6% (Unmet)
	2004	95%	93.9% (Unmet)
	1994	Baseline	74.7%
4. Increase the percentage of contacts of infectious (Acid-Fast Bacillus (AFB) smear-positive) cases that are placed on treatment for latent TB infection and complete a treatment regimen. [O]	2008	> or = 43%	12/2011
	2007	43%	12/2010
	2006	59%	12/2009
	2005	61%	12/2008
	2004	61%	12/2007
	2003	63%	43% (Unmet)
	2002	63%	42% (Unmet)
	1999	Baseline	45.5%
<b>Data Source:</b> Data are obtained from the national TB Surveillance System and the national Aggregate Reports for TB Program Evaluation.			
<b>Data Validation:</b> TB morbidity data and related information submitted via the national TB Surveillance System are entered locally or at the state level into CDC-developed software which contains numerous data validation checks. Data received at CDC are reviewed to confirm their integrity and evaluate completeness. Routine data quality reports are generated to assess data completeness and identify inconsistencies. Data submitted via the national Aggregate Reports for TB Program Evaluation are checked for accuracy and inconsistencies. Problems are resolved by CDC staff working with state and local TB program staff. During regular visits to state, local, and territorial health departments, CDC staff review TB registers and other records and data systems and compare records for verification and accuracy. At the end of each year, data are again reviewed before data and counts are finalized and published.			
<b>Cross Reference:</b> <u>Measure 1</u> - HHS-1, HP-14.11, PART, 500-1; <u>Measure 2</u> – HHS-1, HP-14.12, 500-1; <u>Measure 3</u> - HHS-1; <u>Measure 4</u> - HHS-1, HP-14.13, 500-1			

<sup>1</sup>Data reports come to CDC after therapy is completed, which can be as long as two years.

#### **Goal 11, Performance Measure 1:**

TB is a leading infectious killer of young adults worldwide, claiming the lives of more than two million people each year. Approximately one third of the world's population is latently infected with the bacterium that causes TB. An estimated 10 to 15 million U.S. citizens have latent TB infection, and about 10 percent of these individuals will develop TB at some point in their lives. In 2005, TB cases declined for the 13<sup>th</sup> straight year and, from 2004 to 2005, reported cases of TB in the U.S. declined 2.9 percent (from 14, 515 to 14,097). Persons born outside the U.S. now account for more than half of all U.S. TB cases.

#### **Goal 11, Performance Measure 2:**

Because completion of TB treatment is the most effective way to reduce the spread of TB and prevent its complications, this objective is the highest priority for CDC's TB program. Its achievement is vital to reduce TB cases and to eventually eliminate TB. Patients who do not complete therapy within 12 months are often difficult to treat and require numerous interventions. Significant new efforts must be made to achieve this objective. CDC supports outreach workers, hired from language, cultural, and ethnic groups with high TB incidence to help meet this objective.

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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. The proportion of persons who complete a curative course of treatment within 12 months of initiation rose from 67.6% in 1999 to 81.5% in 2003, however, improvement in this area is still needed.

**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 percentage of TB patients with initial positive cultures who have drug susceptibility results has increased dramatically over the past decade, from 74.7% in 1994 to 94.6% in 2005. Progress towards this measure is attributable to increased efforts of state and local health departments and hospital infection-control practitioners to address the resurgence of TB and increased funding for health department laboratories to purchase state-of-the-art equipment needed to perform more accurate and rapid laboratory testing and confirmation for TB and multi-drug resistant TB.

**Goal 11, Performance Measure 4:**

Completion of treatment for latent TB infection among contacts of infectious TB cases is a cornerstone of U.S. efforts to reduce TB and eliminate the disease, second only to ensuring that those with active TB complete treatment with appropriate drugs. Contacts of smear-positive TB patients are at high risk of developing TB and therefore must be screened for infection. If infected, these contacts should be offered complete treatment for latent infection. Performance reporting dates for FY 2002 – 2006 have been revised to accurately reflect the time lag in reporting data to CDC. In 2000, CDC adopted a new system for reporting on this measure. As a result, baseline data is substantially lower than that gathered under the previous system. Previous targets were set with a different data system which reflected a much higher baseline. The FY 2007 and FY 2008 targets have been revised in consideration of the new baseline data.

Through cooperative agreements with state and local health departments, CDC supports identifying and examining contacts of persons with active TB, as well as completing treatment for contacts who have latent TB infection. CDC is designing training for health department TB staff to improve their skills in this area. CDC is also working with the Health Resources and Services Administration (HRSA) and other federally funded programs serving groups at high risk for TB to facilitate testing and completion of treatment of latent TB infection.

*VIRAL HEPATITIS*

GOAL 12: REDUCE VIRAL HEPATITIS.			
Measure	FY	Target	Result
1. By 2010, reduce the number of new cases of hepatitis A to 2.25 new cases per 100,000 population [O]	2008	<b>2.4 new cases</b>	7/2009
	2007	2.5 new cases	7/2008
	2006	2.6 new cases	7/2007
	2005	2.6 new cases	1.9 (Exceeded)
	1997	Baseline	11.3
Data Source: The National Notifiable Diseases Surveillance System (NNDSS).			
Data Validation: NNDSS data are received from state health departments weekly and reviewed. Reports are checked and any pre-specified data are verified by contacting the appropriate state health department. All data are once again checked and verified with state health departments at the end of each calendar year.			
Cross Reference: HHS-1, PART, H.P. – 14.6			

**Goal 12, Performance Measure 1:**

CDC is on track to achieve the long-term target for hepatitis A. Overall, hepatitis A rates have declined dramatically; more than 78 percent since the last nationwide outbreak in 1995. The Healthy People 2010 target for reducing hepatitis A rates, 4.5 new cases per 100,000 population, was achieved in 2001. The rate in 2005, 1.9 new cases per 100,000 population, is the lowest rate recorded since surveillance for hepatitis A began in 1966. This precipitous decline in hepatitis A rates has coincided with the implementation of the Advisory Committee on Immunization Practices' (ACIP) recommendations for use of hepatitis A vaccine for the prevention and control of hepatitis A. In

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particular, in 1999, the ACIP recommended routine vaccination of children living in 11 states which had consistently elevated hepatitis A rates during the previous decade (1987-1997) and suggested that vaccination be considered in another six states. In 2006, ACIP stated that elimination of indigenous HAV transmission in the U.S. was an attainable goal and recommended universal vaccination of all children at one year of age (e.g. 12 - 23 months) for HAV. 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. Reporting dates for FY 2006, FY 2007 and FY 2008 have been extended as the data will be available in July of 2007. The FY 2006 result will be reported in July of 2007.

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ZOONOTIC, VECTOR-BORNE, AND ENTERIC DISEASES

### **ZOONOTIC, VECTOR-BORNE, AND ENTERIC DISEASES**

Efficiency Measure	FY	Target	Result
1. Enhance detection and control of foodborne outbreaks by increasing the number of foodborne isolates identified, fingerprinted, and electronically submitted to CDC's computerized national database networks with annual level funding. [E]	2008	<b>32,069 isolates</b>	12/2008
	2007	28,633 isolates	12/2007
	2006	24,866 isolates	27,618 (Exceeded)
	2005	21,471 isolates	22,684 (Exceeded)
	2004	17,876 isolates	18,729 (Exceeded)
	2003	Baseline	14,864
<b>Data Source:</b> PulseNet USA national databases established and maintained at CDC.			
<b>Data Validation:</b> Pattern submissions to PulseNet national databases are assessed and reviewed on a daily basis at CDC. Submitters to PulseNet databases are certified for competency before they are given access to the national databases. They are required to complete proficiency testing on an annual basis. Pattern and serotype statistics for all of the PulseNet databases are compiled, verified and reported on a quarterly and annual basis.			
<b>Cross Reference:</b> HHS-8, PART			

#### **Efficiency Measure 1:**

PulseNet, an early warning system for outbreaks of foodborne disease, is a national network of public health laboratories that performs DNA fingerprinting on bacteria that may be foodborne. This network identifies and labels each disease-causing organism by its fingerprint pattern and rapidly compares new patterns to those existing in the electronic database at CDC to identify related strains. The DNA fingerprinting can distinguish strains of disease-causing organisms such as *Escherichia coli* (*E. coli*), *Salmonella*, *Shigella*, and *Listeria*, allowing early detection of disease clusters.

Currently, databases are available for *E. coli*, *Salmonella*, *Listeria monocytogenes*, *Shigella*, and *Campylobacter*. CDC will increase the number of online submissions between 2006 and 2008 by increasing the number of individuals at the participating laboratories who are certified to electronically submit pulsed field gel electrophoresis (PFGE) patterns directly to the database.

<b>GOAL 1: PROTECT AMERICANS FROM INFECTIOUS DISEASES FOODBORNE ILLNESSES.</b>			
Measure	FY	Target	Result
1. By 2010, reduce the incidence of infection with four key foodborne pathogens by 50%. [O]		<i>Campylobacter</i>	<i>Campylobacter</i>
The 2010 targets by pathogen are:  12.30 <i>Campylobacter</i> 1.00 <i>Escherichia coli</i> O157:H7 0.25 <i>Listeria monocytogenes</i> 6.80 <i>Salmonella</i> species	2008	<b>14.20</b>	5/2009
	2007	15.14	5/2008
	2006	16.10	5/2007
	2005	17.03	12.72 (Exceeded)
		<i>Escherichia coli</i> O157:H7	<i>Escherichia coli</i> O157:H7
	2008	<b>1.20</b>	5/2009
	2007	1.25	5/2008
	2006	1.30	5/2007
	2005	1.42	1.06 (Exceeded)
		<i>Listeria monocytogenes</i>	<i>Listeria monocytogenes</i>
	2008	<b>0.29</b>	5/2009
	2007	0.31	5/2008
	2006	0.33	5/2007
	2005	0.35	0.30 (Exceeded)

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**GOAL 1: PROTECT AMERICANS FROM INFECTIOUS DISEASES FOODBORNE ILLNESSES.**

Measure	FY	Target	Result
		<i>Salmonella</i> species	<i>Salmonella</i> species
	2008	<b>7.90</b>	5/2009
	2007	8.39	5/2008
	2006	8.90	5/2007
	2005	9.45	14.55 (Unmet)

**Data Source:** FoodNet (The Foodborne Diseases Active Surveillance Network) Data.

**Data Validation:** FoodNet data are transmitted, updated, and reviewed monthly. Incomplete data are reviewed with sites on a monthly basis, as are cross checks comparing local data with national data for data validity. Data are closed out and summarized on an annual cycle to produce preliminary reports, published in MMWR in spring of the following year, and a final report, later that year, once the updated population denominator data are available from the US Bureau of Census.

**Cross Reference:** HHS-1, PART

**Goal 1, Performance Measure 1:**

A summary of FoodNet data from 1996 to 2005 published on April 14, 2006, showed significant declines in rates of infection with *E. coli* O157, *Listeria*, and *Campylobacter*, suggesting the current efforts to reduce these diseases are largely on track toward the Healthy People 2010 objectives. Rates of infection with *Salmonella* have only modestly decreased. This may reflect increasing *Salmonella* contamination in poultry and challenges related to fresh produce. New interagency efforts in research and interventions to improve the effectiveness of food safety measures for *Salmonella* are now underway. CDC, in collaboration with FDA, began broad implementation of a national *Listeria* Action Plan to further reduce *Listeria* cases through efficient risk management, by empowering consumers and improving consumer safety.

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**PREPAREDNESS, DETECTION, AND CONTROL OF INFECTIOUS DISEASES**

**ANTIMICROBIAL RESISTANCE**

<b>GOAL 1: REDUCE THE SPREAD OF ANTIMICROBIAL RESISTANCE.</b>			
<b>Measure</b>	<b>FY</b>	<b>Target</b>	<b>Result</b>
1. Reduce the number of courses of antibiotics for ear infections for children < 5 years to 57 courses per 100 children. [O]	2006	60 courses	11/2007
	2005	61 courses	47 (Exceeded)
	2004	62 courses	42 (Exceeded)
	2003	63 courses	53 (Exceeded)
2. Reduce the number of courses of antibiotics prescribed for a sole diagnosis of the common cold to 1,268 courses per 100,000 population. [O]	2005	1,917 courses	1,376 (Exceeded)
	2004	1,917 courses	1,007 (Exceeded)
	2003	2,017 courses	1,871 (Exceeded)
	2002	2,144 courses	1,913 (Exceeded)
3. Decrease the number of antibiotics prescribed for ear infections in children under 5 years of age per 100 children. [O]	2008	<b>57 courses</b>	11/2009
	2007	60 courses	11/2008
	2006	60 courses	11/2007
	2005	61 courses	50 (Exceeded)
<b>Data Source:</b> Measures 1 - 3: National Ambulatory Medical Care Survey (NAMCS), CDC, NCHS; NHAMCS, CDC, NCHS.			
<b>Data Validation:</b> A 10% quality control sample of survey records was independently keyed and coded.			
<b>Cross Reference:</b> Measure 1 - HHS-1, HP-14.18; Measure 2 - HHS-1, HP-14.19; Measure 3 - HHS-4, 5, HP-14.18, PART			

**Goal 1, Performance Measures 1 and 3:**

The number of courses of antibiotics given for ear infections to children under five years of age declined from 63 courses per 100 population in 2002 to 53 courses per 100 population in 2003 and decreased further to 42 per 100 population in 2004. Data from 2005 show a slight increase; however, the goal is still exceeded. Data show that antibiotic prescriptions for ear infections in children under five have declined considerably, compared to the 1997 baseline of 69 courses. Measure 1 will be retired after data are reported for FY 2006. Reporting dates for both measures 1 and 3 were extended to November in order to give the appropriate time to collect and report data accurately.

CDC's public health campaign "Get Smart: Know When Antibiotics Work" is the focus of this measure. The campaign involves an alliance of partners working to reduce inappropriate antibiotic use and reduce the spread of resistance to antibiotics. This national campaign includes a series of television, radio, and print public service announcements and comprehensive national, state, and local outreach. For example, in September 2003, CDC launched a national ad campaign created to promote appropriate antibiotics use knowledge among parents, which generated over 90 million audience impressions through television, print, and online media. Other current campaign activities include funding states to develop, implement, and evaluate local campaigns and evaluating and promoting a medical school curriculum on appropriate use of antibiotics. In addition, the National Committee for Quality Assurance's Health Plan Employer Data and Information Set (HEDIS) now includes two measures on appropriate antibiotic use, promoted through the campaign.

In May 2004, the American Academy of Pediatrics and the American Academy of Family Physicians issued new guidelines for the management of ear infections. These guidelines present an option of observing selected children with ear infections without prescribing an antibiotic. CDC expects that as these guidelines are implemented prescribing antibiotics for ear infections will decline, accelerating movement toward achieving this goal.

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**Goal 1, Performance Measure 2:**

Because the common cold is caused by a virus, antibiotic therapy is ineffective in treating these infections. Reducing the use of antibiotics in the treatment of the common cold remains one of the prime targets of CDC's antimicrobial resistance campaign. Success in exceeding this measure may reflect efforts by CDC and partners to promote appropriate antibiotic use in the community. Now that the data for FY 2005 have been reported, this measure is retired and will not be reflected in future performance detail.

*MEDICAL ERRORS AND HEALTHCARE-ASSOCIATED INFECTIONS*

<b>GOAL 2: PROTECT AMERICANS FROM DEATH AND SERIOUS HARM CAUSED BY MEDICAL ERRORS AND PREVENTABLE COMPLICATIONS OF HEALTHCARE.</b>			
<b>Measure</b>	<b>FY</b>	<b>Target</b>	<b>Result</b>
1. Reduce the rate of central line-associated bloodstream infections in adult ICU patients to 3.8. [O]	2005	3.8	3.0 (Exceeded)
	2004	3.8	3.5 (Exceeded)
	2003	3.8	4.0 (Unmet)
	2002	3.8	4.3 (Unmet)
2. Reduce the rate of central line associated bloodstream infections in medical/surgical ICU patients. [O]	2008	<b>3.54</b>	5/2009
	2007	3.54	5/2008
	2006	3.58	5/2007
	2005	3.62	3.5 (Exceeded)
	2004	3.66	3.6 (Met)
	2003	Baseline	3.7
<b>Data Source:</b> Before December 2004 - National Nosocomial Infections Surveillance (NNIS) system. After January 2005 - National Healthcare Safety Network (NHSN), which replaced NNIS.			
<b>Data Validation:</b> Extensive cross-field edit checks ensure the accuracy of the data, incomplete data cannot be transmitted. Detailed instructions for completion of report forms ensure consistency across sites. Process and quality improvements occur through email updates and annual meetings.			
<b>Cross Reference:</b> <u>Measure 1</u> - HHS-1, 5, 500-1; <u>Measure 2</u> - HHS-1, 5, PART, 500-1			

**Goal 2, Performance Measure 1:**

The FY 2004 target for reducing central line-associated bloodstream infections was exceeded. Now that the data for FY 2005 have been reported, the measure is retired and will not be reflected in future performance detail.

**Goal 2, Performance Measure 2:**

This measure uses data from combined medical/surgical intensive care units (ICUs) from hospitals not designated as major teaching facilities because they are the most prevalent unit reported in NNIS System and thus, most representative. From 2004 to 2005, the rate of central-line associated bloodstream infections in medical/surgical ICUs in non-major teaching hospitals decreased from 3.6 in 2004 to 3.5 in 2005.

<b>GOAL 3: PROTECT AMERICANS FROM INFECTIOUS DISEASES LABORATORY RESPONSE.</b>			
<b>Measure</b>	<b>FY</b>	<b>Target</b>	<b>Result</b>
1. Increase the percentage of Laboratory Response Network (LRN) labs with cumulative proficiency testing scores of 90% or better.	2008	<b>88% of labs</b>	12/2008
	2007	88% of labs	12/2007
	2006	84% of labs	88% (Exceeded)
	2005	80% of labs	88% (Exceeded)
	2004	Baseline	79%

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PREPAREDNESS, DETECTION, AND CONTROL OF INFECTIOUS DISEASES

**GOAL 3: PROTECT AMERICANS FROM INFECTIOUS DISEASES   LABORATORY RESPONSE.**

**Data Source:** LRN labs report Proficiency Testing (PT) data to LRN secure website. Grading and summary of results are maintained on LRN website.

**Data Validation:** All of PT results are reviewed to meet grading criteria: 1. Proper identification of agent in the samples that contain the agent; 2. Ability of LRN labs to follow appropriate algorithm for obtaining results; 3. Ability to report with prescribed timelines. Automated grading tool is used to calculate PT passing rates. Designated individual review PT grading for errors.

**Cross Reference:** HHS-4, 5, PART, 500-4

**Goal 3, Performance Measure 1:**

The purpose of proficiency testing (PT) is to determine if LRN laboratories are continuously able to accurately identify the biological agents that may appear in naturally-occurring outbreaks or that may be used as agents of bioterrorism by using the instruments and protocols employed by the LRN. CDC provides a special PT program to each LRN laboratory that is, in turn, required to successfully participate. With each event, the PT program sends one or more select agents to each laboratory as pure cultures, genetic fragments, or substances embedded in a sample matrix mimicking an environmental powder or other sample. Laboratories are challenged to provide the correct genus and species answer using the established protocols within a limited and specified timeframe. The cumulative PT score for a year is calculated by averaging the scores from each quarterly PT and then at the end of the year, calculating a national average from the total number of sites that participate in the program.

The PT program has been in place since the LRN was initiated in 1999. At the onset of the program, very few state laboratories were able to rapidly and accurately identify biological and select agents. Because of the difficulty in identifying certain select agents and logistical issues, the success rate in 2003 was about 75 percent. In order to achieve a goal of a cumulative average of 90 percent or greater for all labs in the LRN, it is necessary to maintain constant communication regarding the standard operating plan regarding specimen analysis, to provide updates on protocols, to provide remediation and training to those laboratories that do not achieve the 95 percent goal, and to engage the Association of Public Health Laboratories (APHL) to assist in achieving this national goal. APHL has agreed to assume responsibility for monitoring its members. By the middle of FY 2005 the average was only 83 percent accuracy (88 percent by the end of FY 2005). Because of these averages, and because some organisms are very difficult to identify, the goal of reaching and maintaining 90 percent on a national scale is ambitious. While the goal of the LRN is to achieve a 100 percent accuracy rate, it is reasonable to assume that successful participation on a national scale would entail a success rate of 90 percent or greater accuracy.

## HEALTH PROMOTION

### CHRONIC DISEASE PREVENTION, HEALTH PROMOTION, AND GENOMICS

The Chronic Disease Prevention, Health Promotion, and Genomics program underwent OMB's Program Assessment Rating Tool (PART) review process in 2006 in preparation for the FY 2008 President's Budget. As a result, many performance measures have been retired and new goals and measures approved through the PART process have been added.

Efficiency Measure	FY	Target	Result
1. Increase the number of Web-based management information systems (MIS) resulting in savings of program staff time. [E]	2006	6	6 (Met)
	2005	6	7 (Met)
	2004	N/A	5
	2003	Baseline	4
2. Number of financial actions (such as project carryover funds requests from grantees and grantee project re-budgetings) that delay the implementation of grantee and partners' activities. (E)	2008	<b>419</b>	12/2008
	2007	433	12/2007
	2005	Baseline	466
<b>Data Source:</b> <u>Measure 1</u> - All IT operations are centralized and MIS's are deployed only when activated by Center IT staff. They keep track of all active and developmental MIS's. <u>Measure 2</u> - The Extramural Programs Management Information System (EPMIS), which is an internal system for tracking and managing all types of budget actions.			
<b>Data Validation:</b> <u>Measure 1</u> - Center Information Systems Lead monitors active and developmental MIS's as part of normal duties. <u>Measure 2</u> – EPMIS report will be run periodically and results authenticated by Division budget leads at monthly meetings with Center budget execution staff.			
<b>Cross Reference:</b> <u>Measure 1</u> - HHS-5, 8; <u>Measure 2</u> – HHS-5, 8, PART			

#### **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 six information systems to collect programmatic information: (1) Racial and Ethnic Approaches to Community Health Management Information System (REACH MIS), (2) Office of Smoking and Health's (OSH) National Tobacco Control Program Chronicle, (3) National Breast and Cervical Cancer Early Detection Program (NBCCEDP) Minimum Data Elements (MDE), (4) Division of Diabetes Translation Management Information System, (5) Prevention Research Center Information System and (6) Heart Disease and Stroke Management Information System. The NBCCEDP System for Technical Assistance Reporting (STAR) to report programmatic infrastructure data has been discontinued following an internal evaluation of the efficiency and usefulness of the data collection. Due to the development of a Center-wide efficiency measure during the PART process, this measure will be retired after data are reported for FY 2006.

Additionally, efficiency measures previously reported for Breast and Cervical Cancer prevention and Diabetes have been subsumed into the new Center-wide efficiency measure. Now that the data for FY 2006 have been reported, the measure is retired and will not be reflected in future performance detail.

#### **Efficiency Measure 2:**

Approximately 85 percent of CDC's National Center for Chronic Disease Prevention and Health Promotion's (NCCDPHP) budget is spent on extramural funding of grantees and cooperative agreement partners, especially state health departments. These grantees and partners utilize funding to conduct interventions that directly impact the health of the nation. Any delay in receipt of funding results in reduction of the number or duration of the interventions, which, in turn, affects the health impact of our grantees' activities.

Based on recent implementation of a Project Officer training course, increased use of Management Information Systems to track these actions, and increased emphasis on technical assistance, the program will decrease these budget actions each year. Targets reflect a five percent decrease from baseline per year.

*HEART DISEASE AND STROKE*

<b>GOAL 1: REDUCE DEATH AND DISABILITY DUE TO HEART DISEASE AND STROKE AND ELIMINATE DISPARITIES.</b>			
<b>Measure</b>	<b>FY</b>	<b>Target</b>	<b>Result</b>
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]	2006	Heart disease deaths 45%; Stroke deaths 43%	2/2009
	2005	Heart disease deaths 45%; Stroke deaths 43%	2/2008
	2004	Heart disease deaths 45%; Stroke deaths 43%	2/2007
	2003 <sup>1</sup>	N/A	Heart disease deaths 49%; Stroke deaths 46%
	2002	N/A	Heart disease deaths 48%; Stroke deaths 45%
	2001	Baseline	Heart disease deaths 47%; Stroke deaths 44%
2. Reduce the prevalence of uncontrolled high blood pressure (>140/90) among patients with hypertension, especially among populations at high risk, in states that collaborate with community health centers. [O]	2006	50%	63% (Unmet)
	2005	50%	57% (Unmet)
	2004	50%	54% (Unmet)
	2003	N/A	60%
	2002	Baseline	60%
<b>Data Source:</b> CDC evaluates stroke registry capacity via annual state reports, deaths from heart disease and stroke via death certificate data from states, and uncontrolled high blood pressure data from HRSA and NCHS.			
<b>Data Validation:</b> Data is validated within HRSA and NCHS.			
<b>Cross Reference:</b> <a href="#">Measure 1</a> - HHS-1, 5,HP-12; <a href="#">Measure 2</a> - HHS-1, 5, 6, HP-12.1, 500-1			

<sup>1</sup>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 which cover symptom awareness and the need to call 911 for emergency transport. Intra and inter-state stroke networks, coalitions, and signs and symptoms campaigns have been developed. This measure will be retired after data are reported for FY 2006.

**Goal 1, Performance Measure 2:**

Program activities to achieve the performance measure of reducing the prevalence of uncontrolled high blood pressure among high-risk populations and patients with hypertension include collaborations between states and their Federally Qualified Community Health Centers, which provide healthcare to underserved, uninsured, and minority populations. To date, states have assisted health centers in conducting needs assessments, and providing hypertension training and educational assistance for providers related to national guidelines for hypertension care and prevention.

Community health centers continue to enhance and align their systems and practices with evidence-based recommendations to reduce heart disease and stroke risk factors. In FY 2006, HRSA merged the Cardiovascular Health Collaborative with the Diabetes Collaborative. Training and startup time led to a decrease in the desired effect. With the completion of the merger and training, it is anticipated that these results will improve. Now that the data for FY 2006 have been reported, the measure is retired and will not be reflected in future performance detail.

**EARLY DETECTION OF BREAST AND CERVICAL CANCER**

**GOAL 2: INCREASE EARLY DETECTION OF BREAST AND CERVICAL CANCER BY BUILDING NATIONWIDE PROGRAMS IN BREAST AND CERVICAL CANCER PREVENTION, ESPECIALLY AMONG HIGH RISK, UNDERSERVED WOMEN.**

Measure	FY	Target	Result
1. Excluding invasive cervical cancers diagnosed on an initial screen in NBCCEDP, lower the age-adjusted rate of invasive cervical cancer in women aged 20 and older. [O]	2006	<14/100,000 <sup>1</sup>	2/2008†
	2005	<14/100,000 <sup>1</sup>	2/2007†
	2004	<15/100,000 <sup>1</sup>	17/100,000 (Unmet)
	2003	<16/100,000 <sup>1</sup>	15/100,000 (Exceeded)
	2002	<22/100,000	15/100,000 (Exceeded)
<b>Data Source:</b> Minimum Data Elements (MDEs).			
<b>Data Validation:</b> States, territories, and tribal organizations (NBCCEDP grantees) submit MDEs electronically twice a year (October 15 and April 15) to a data management contractor, who analyzes the data and submits analysis data to CDC in July and February. All data collected and submitted by NBCCEDP grantees have indicators to assess completeness. Data are also assessed against established clinical standards.			
<b>Cross Reference:</b> HHS-1, HP-3.4, 500-1,3			

<sup>1</sup> FY rate based on 3 years of data (see narrative text below).

**Goal 2, Performance Measure 1:**

Beginning in 2003, CDC moved to calculating this rate based on a rolling three-year timeframe rather than cumulative data (for instance, the FY 2003 rate reflects data for the time period 2001–2003). Using a three-year period ensures statistical stability in the rate.

Rates increased in FY 2004 and did not reach the target. CDC will continue to analyze these data and evaluate the measurements, policies and programs in place to determine why this target was not met. This measure will be retired after data are reported for FY 2006.

**GOAL 3: EXPAND COMMUNITY BASED BREAST AND CERVICAL CANCER SCREENING AND DIAGNOSTIC SERVICES TO LOW INCOME, MEDICALLY UNDERSERVED WOMEN. FOR WOMEN DIAGNOSED WITH CANCER OR PRE CANCER, ENSURE ACCESS TO TREATMENT SERVICES.**

Measure	FY	Target	Result
1. Increase the number of women screened. [O]  Breast: mammogram or Clinical Breast Examination (CBE) Cervical: Pap Smear	2006	Breast 401,000; Cervical 280,000	2/2008
	2005	Breast 401,000; Cervical 280,000	2/2007
	2004	Breast 381,682; Cervical 275,000	Breast 558,846 (Exceeded) Cervical 329,645 (Exceeded)
	2003	N/A	Breast 537,619; Cervical 304,407
	2002	N/A	Breast 394,146; Cervical 280,330
	2000	Baseline	Breast: 229,000; Cervical: 247,192
2. Increase the percentage of newly enrolled women who have not received a Pap test within the past 5 years. [O]	2006	Cervical 25%	2/2008
	2005	Cervical 25%	2/2007
	2004	Cervical 22.5%	22.1% (Unmet)
	2003	Cervical 22.5%	21.3% (Unmet)
	2002	N/A	22.2%
	2000	Baseline	Cervical 21.7%

**PERFORMANCE DETAIL**  
**HEALTH PROMOTION**  
**CHRONIC DISEASE PREVENTION, HEALTH PROMOTION, AND GENOMICS**

**GOAL 3: EXPAND COMMUNITY BASED BREAST AND CERVICAL CANCER SCREENING AND DIAGNOSTIC SERVICES TO LOW INCOME, MEDICALLY UNDERSERVED WOMEN. FOR WOMEN DIAGNOSED WITH CANCER OR PRE CANCER, ENSURE ACCESS TO TREATMENT SERVICES.**

Measure	FY	Target	Result
3. Increase the percentage of women with abnormal results who receive a final diagnosis within 60 days of screening. [O]  Breast: abnormal mammogram (suspicious of abnormality, highly suggestive of malignancy, or assessment incomplete) and/or abnormal CBE  Cervical: abnormal Pap includes high grade SIL, squamous cancer, or abnormal glandular cells	2006	Breast 87.5%; Cervical 64.5%	2/2008
	2005	Breast 87.5%; Cervical 64.5%	2/2007
	2004	Breast 86.5%; Cervical 64%	Breast 80.7% (Unmet) Cervical 62.6% (Unmet)
	2003	N/A	Breast 81.4%; Cervical 62.0%
	2002	N/A	Breast 82.8%; Cervical 63.0%
	2000	Baseline	Breast: 82.2%; Cervical: 61.2%
4. Increase the percentage of women with cancer who start treatment within 60 days of diagnosis. [O]	2006	Breast 95.5%; Cervical 92.5%	2/2008
	2005	Breast 95.5%; Cervical 92.5%	2/2007
	2004	Breast 95%; Cervical 92%	Breast 93.1% (Unmet) Cervical 87.6% (Unmet)
	2003	N/A	Breast 93.0%; Cervical 91.9%
	2002	N/A	Breast 92.9%; Cervical 88.6%
	2000	Baseline	Breast: 94%; Cervical: 88%
5. Cervical: Increase the percentage of women with precancerous lesions who start treatment within 90 days of diagnosis (includes CIN (cervical intraepithelial neoplasia) II, CIN III, and CIS). [O]	2006	94.5%	2/2008
	2005	94.5%	2/2007
	2004	94%	90.4% (Unmet)
	2003	N/A	89.0%
	2002	N/A	90.3%
	2000	Baseline	92.4%

**Data Source:** MDE is used.

**Data Validation:** Please refer to the previous performance table for a detailed explanation.

**Cross Reference:** Measure 1 - HHS-1, 3, 5, 6,HP-3.3, 3.4, 3.10, 500-1,3; Measure 2 - HHS-1, 3, 5, 6,HP-3.4, PART, 500-1,3; Measure 3 - HHS-1, 3, 5, 6,HP-3.3, 3.4, 500-1,3; Measure 4 - HHS-1, 3, 5, 6,HP-3.3, 3.4, PART, 500-1,3; Measure 5 - HHS-1, 3, 5, 6,HP-3.4, 500-1,3

**Goal 3, Performance Measure 1:**

CDC continues to increase the number of women screened through NBCCEDP by providing support for community outreach, education and recruitment. CDC also encourages programs to partner and/or collaborate with traditional and non-traditional partners to increase visibility, recruit eligible women, and increase provider networks. This measure will be retired after data are reported for FY 2006.

**Goal 3, Performance Measure 2:**

CDC encourages programs to reach underserved women for screening, including women who are rarely or never screened for cervical cancer. CDC defines "never or rarely screened" women as those who have not had a Pap test within the past five years. In FY 2004, 22.1 percent of newly enrolled women were rarely or never screened, just below our target of 22.5 percent and an increase from FY 2003. Because the measure relates only to newly enrolled women, projects must enroll new, rarely, and never screened women each year to meet this target. Therefore, it is a challenging target to achieve over time because programs must continually tap into communities to identify those who are rarely or never screened. This measure will be retired after data are reported for FY 2006.

**Goal 3, Performance Measure 3:**

In FY 2004, 80.7 percent of women with abnormal breast cancer screening results and 62.6 percent of women with abnormal cervical cancer screening results received a final diagnosis within 60 days. The FY 2004 figures represent a decrease in breast and increase in cervical timeliness of diagnostic follow-up over the FY 2003 figures. The comparatively lower percentage for cervical cancer screening reflects challenges facing CDC's programs, including delays in Pap results reporting from laboratories, long waiting periods for appointments for diagnostic services, and difficulties in tracking "hard to reach" women. Successful recall of women for diagnostic evaluation following unsuccessful earlier attempts will improve rates for completeness of follow-up, though negatively impacting timeliness. This measure will be retired after data are reported for FY 2006.

**Goal 3, Performance Measure 4:**

With the rapid expansion of screening services provided by the program (Goal 3, Measure 1), rates of timeliness to treatment fell short of targets. In FY 2004, 93.1 percent of women diagnosed with breast cancer and 87.6 percent of women diagnosed with invasive cervical cancer initiated treatment within 60 days. This is a slight improvement over FY 2003 for breast cancer and decline for cervical cancer. Rates and percentages are more stable when calculated from large numbers. Because the number of invasive cancer cases diagnosed through the program in FY 2004 is small (201 cases), trends based on annual measures for cervical cancer trends may be difficult to interpret. This measure will be retired after data are reported for FY 2006.

**Goal 3, Performance Measure 5:**

For women diagnosed with precancerous cervical lesions, CDC has set a target of ensuring the start of treatment within 90 days to 94 percent in 2004 and 94.5 percent in FY 2005. In 2000, the baseline for women diagnosed with precancerous cervical lesions that start treatment within 90 days was established at 92.5 percent. With the rapid expansion of screening services provided by the program (Goal 3, Measure 1), rates of timeliness to treatment fell short of targets. In FY 2004, the percentage of women with precancerous lesions who started treatment within 90 days of diagnosis was 90.4 percent, an increase from FY 2003. This measure will be retired after data are reported for FY 2006.

*DIABETES PREVENTION AND CONTROL*

<b>GOAL 4: INCREASE THE CAPACITY OF STATE DIABETES CONTROL PROGRAMS TO ADDRESS THE PREVENTION OF DIABETES AND ITS COMPLICATIONS AT THE COMMUNITY LEVEL.</b>			
<b>Measure</b>	<b>FY</b>	<b>Target</b>	<b>Result</b>
1. For states receiving CDC funding for Diabetes Prevention and Control Programs (DPCPs), increase the percentage of persons with diabetes who receive annual eye and foot exams. [O]	2006	Eye 75%; Foot 70%	10/2007
	2005	Eye 75%; Foot 70%	Eye 60.6% (Unmet); Foot 66.0% (Unmet)
	2004	Eye 72%; Foot 62%	Eye 61.9% (Unmet); Foot 66.6% (Exceeded)
	2003	Eye 72%; Foot 62%	Eye 61.3% (Unmet); Foot 67.4% (Exceeded)
	2002	Eye 72%; Foot 62%	Eye 64.2% (Unmet); Foot 66.6% (Exceeded)
2. For states receiving CDC funding for DPCPs, increase the percentage of persons with diabetes who receive at least two A1c measures per year. [O]	2006	72.5%	10/2007
	2005	72.5%	64.3% (Unmet)
	2004	72.5%	68.8% (Unmet)
	2003	N/A	63.3%
	2002	Baseline	62.0%

**GOAL 4: INCREASE THE CAPACITY OF STATE DIABETES CONTROL PROGRAMS TO ADDRESS THE PREVENTION OF DIABETES AND ITS COMPLICATIONS AT THE COMMUNITY LEVEL.**

Measure	FY	Target	Result
3. Increase the number of DPCPs that promote health system approaches among those who are at high risk for developing diabetes (New initiative).	2006	5	10/2007
	2005	5	5 (Met)
	2004	5	5 (Met)
	2002	Baseline	0
<b>Data Source:</b> Data on receipt of annual eye and foot exams in persons with diabetes is collected through BRFSS.			
<b>Data Validation:</b> More than 30 validity and reliability studies attest to the quality and validity of data derived from the BRFSS. CDC verifies performance through quarterly state reports and periodic site visits. For efforts in American Indian/Alaska Native populations, data are verified via program reports and documentation of support. Also, CDC staff work closely with the Indian Health Service in validating data pertaining to American Indian/Alaskan Natives.			
<b>Cross Reference:</b> <u>Measure 1</u> - HHS-1, 3, HP-5.13, 5.14, PART, 500-1, 3; <u>Measure 2</u> - HHS-1, 3,HP-5.12, PART; <u>Measure 3</u> - HHS-1, 6, HP-5.2, 500-1, 3			

**Goal 4, Performance Measure 1:**

In FY 2003, CDC began analyzing the Behavioral Risk Factor Surveillance System (BRFSS) data for this measure. Rather than focusing solely on basic implementation DPCPs, CDC now analyzes data from all the basic implementation and capacity building DPCPs participating in the BRFSS. CDC is now also using adjusted data rather than crude data.

Dilated eye exams leveled off in FY 2003 and dropped slightly in FY 2005. This may be due to a number of factors, including a possible increase in the use of fundus photography, a new technology that does not require dilation. For this reason, CDC is considering revising the BRFSS question which measures this objective. Also, recent studies have suggested that dilated eye exams performed every two years instead of annually are sufficient to prevent blindness from diabetic retinopathy in those without the condition. 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. This measure will be retired after data are reported for FY 2006.

**Goal 4, Performance Measure 2:**

This measure captures funded states progress in increasing A1c testing rates to the recommended level. The A1c test (short for hemoglobin A1c) measures blood glucose (sugar) control over the last three months. The suggested target for people with diabetes is seven percent; however, many people with diabetes have levels of nine percent or higher. Reducing blood glucose levels by just one percent among people with diabetes reduces their risk for microvascular complications (eye, kidney, and nerve disease) by 40 percent. This measure reflects the evolution of CDC's focus from process outputs to intermediate impact outcomes. There has been no clear trend in A1c testing over the last five years as rates have fluctuated slightly from year to year. This measure will be retired after data are reported for FY 2006.

**Goal 4, Performance Measure 3:**

CDC and its state-based DPCPs work with HRSA's Bureau of Primary Health Care and the Institute for Healthcare Improvement (IHI) to improve diabetes and pre-diabetes performance measures through improved care delivery systems, increased access, and decreased health disparities among medically underserved populations. The Diabetes Prevention Collaborative prototype involves five federally funded health centers and five DPCPs from across the country. The objectives of the Diabetes Prevention Collaborative are to identify the pre-diabetes population and those at highest risk for developing diabetes, and provide evidence-based lifestyle interventions to prevent and/or delay the progression to diabetes. Preliminary findings indicate that methods to identify the pre-diabetes population are effective. Lifestyle interventions are being tested for their effect on reaching population level goals of more than seven percent weight loss and more than 150 minutes of exercise per week.

To date, 2,387 individuals who have met the risk criteria for pre-diabetes have received an oral glucose tolerance test; more than half of these individuals (1,392) were found to have either pre-diabetes or previously undiagnosed diabetes. The collaborative shows that better outcomes in diabetes care and prevention are possible when the focus is on empowering individuals, improving the health care delivery system, and linking to communities where people live. This measure will be retired after data are reported for FY 2006.

*TOBACCO USE PREVENTION*

<b>GOAL 5: REDUCE CIGARETTE SMOKING AMONG YOUTH.</b>			
<b>Measure</b>	<b>FY</b>	<b>Target</b>	<b>Result</b>
1. Reduce the percentage of youth (grades 9-12) who smoke. [O]	2005	20.2	23.0% (Unmet)
	2003	26.5	21.9% (Exceeded)
	2001	34.2 <sup>1</sup>	28.5% (Exceeded)
<b>Data Source:</b> CDC monitors cigarette use among youth and reports performance on a biennial basis using the national Youth Risk Behavior Survey (YRBS). Three additional surveys, the National Survey on Drug Use and Health (NSDUH), the Monitoring the Future (MTF) Survey, and the National Youth Tobacco Survey (NYTS), provide complementary data for examining trends and understanding youth-related tobacco issues. The NSDUH is conducted annually by SAMHSA; the MTF is conducted annually by the University of Michigan's Institute for Social Research, and funded by NIDA. The NYTS is conducted by CDC.			
<b>Data Validation:</b> Following procedures developed by CDC staff, the NYTS data collection and survey support contractor, Macro International Inc. (Macro) checked each student's responses to certain questionnaire items for consistency with other items. Upon receipt of the final cleaned 2004 NYTS data set from Macro, CDC staff conducted quality checks of data quality, survey design, and weighting.			
<b>Cross Reference:</b> <a href="#">Measure 1</a> - HHS-1, 7,HP-27.2, 500-1, 3			

<sup>1</sup> 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 nine – twelve) increased from 27.5 percent to 36.4 percent. Since 1997, cigarette use among adolescents has declined substantially, and in 2003, this rate was at the lowest level since national surveys have been monitoring youth smoking. Factors that contributed to the decline included: 1) a 90 percent increase in the retail price of cigarettes from December 1997-May 2003, 2) increases in school-based efforts to prevent tobacco use, and 3) an increase in the proportion of young persons exposed through the mass media to smoking-prevention campaigns. All of these factors are components and/or recommendations of CDC's National Tobacco Control Program. However, the 2005 YRBS and other youth tobacco use surveys indicate that since 2003 this observed rate of decline may be reversing. From 2002 to 2004, factors preventing tobacco use (e.g., increasing the retail price of tobacco products, implementing smoking-prevention media campaigns, and funding for comprehensive state tobacco prevention and control programs) have declined. Meanwhile tobacco industry expenditures on tobacco advertising and promotion have been increasing, from \$5.7 billion in 1997 to \$15.2 billion in 2003. The emerging data underscore the need to fully implement evidence-based strategies that are effective in preventing youth tobacco use in order to continue progress toward meeting the Healthy People 2010 objective of reducing smoking among high school youth to 16 percent. Now that the data for FY 2005 have been reported, the measure is retired and will not be reflected in future performance detail.

*NUTRITION AND PHYSICAL ACTIVITY PROGRAMS TO PREVENT OBESITY AND OTHER CHRONIC DISEASES*

<b>GOAL 6: DECREASE LEVELS OF OBESITY, OR REDUCE THE RATE OF GROWTH OF OBESITY, IN COMMUNITIES THROUGH NUTRITION AND PHYSICAL ACTIVITY INTERVENTIONS.</b>			
<b>Measure</b>	<b>FY</b>	<b>Target</b>	<b>Result</b>
1. Increase the number of nutrition and physical activity interventions that are implemented and evaluated in funded states.	2006	25 interventions	12/2007
	2005	20 interventions	81 (Exceeded)
	2004	12 interventions	12 (Met)
	2002	Baseline	0 interventions
<b>Data Source:</b> CDC plans to collect and evaluate state data on nutrition and physical activity programs via annual state program reports, semi-annual progress monitoring reports, site visit reports, and a program evaluation database.			
<b>Data Validation:</b> Data is verified through submission of additional documentation, follow-up telephone calls, site visits, and other meetings.			
<b>Cross Reference:</b> <a href="#">Measure 1</a> - HHS-1, 5,HP-19, 22, 500-1, 3			

**Goal 6, Performance Measure 1:**

Since the inception of the program in FY 1999, funded states have been forming statewide coalitions, developing statewide action plans, and initiating and evaluating interventions. State partners include public health organizations, food producers and marketers, medical and education providers, parks and recreation, transportation, and urban planning agencies, local media, and communities. All states are developing, implementing and evaluating nutrition and physical activity health promotion interventions to address overweight and chronic disease in specific populations. At a minimum, these interventions are grounded in theory, have a defined purpose with clearly stated expected outcomes, have a defined methodology and strategy for implementation, and an evaluation component. In addition, these interventions are designed to:

- Establish supportive environments, making healthier lifestyle options (i.e., healthy eating and physical activity) in communities more readily accessible, affordable, comfortable, and safe.
- Establish policies and standards to support healthy eating and physical activity in communities.
- Establish programs in communities to increase physical activity and/or reduce caloric intake through healthy eating habits.
- Teach skills needed to make individual behavior changes related to nutrition, physical activity, and healthy weight, and designed to provide opportunities to practice these skills.

This measure will be retired after data are reported for FY 2006.

*SCHOOL HEALTH PROGRAMS*

<b>GOAL 7: REDUCE THE PERCENTAGE OF HIV/AIDS RELATED RISK BEHAVIORS AMONG SCHOOL AGED YOUTH THROUGH DISSEMINATION OF HIV PREVENTION EDUCATION PROGRAMS.</b>			
<b>Measure</b>	<b>FY</b>	<b>Target</b>	<b>Result</b>
1. Achieve and maintain the percentage of high school students who are taught about HIV/AIDS prevention in school at 90% or greater. [O]	2005	90% or more	87.9% (Unmet)
	2003	90% or more	87.9% (Unmet)
	2001	90% or more	89% (Unmet)
2. Increase the proportion of adolescents (grades 9–12) who abstain from sexual intercourse or use condoms if currently sexually active. [O]	2005	89%	87.5% (Unmet)
	2003	89%	87.5% (Unmet)
	2001	89%	86% (Unmet)
	African-American adolescents	African-American adolescents	
	2005	87%	85.5% (Unmet)
	2003	87%	87% (Met)
	2001	87%	85% (Unmet)
	Hispanic adolescents	Hispanic adolescents	
	2005	88%	85.3% (Unmet)
	2003	88%	84.4% (Unmet)
	2001	88%	84% (Unmet)

**Data Source\***: Data for both measures is collected through YBRSS. Data are released biennially.

**Data Validation**: Validity and reliability studies of the YRBSS attest to the quality of the data. CDC conducts quality control checks and logical edit checks on each record.

**Cross Reference**: Measure 1 - HHS-1, 2, 5, 7, HP-25, 500-1, 5; Measure 2 - HHS-1, 7, HP-25.11, 500-1, 5

**Goal 7, Performance Measure 1:**

Data from the 2005 national YBRSS indicate that this measure has decreased since 1997 (92 percent) and that the small fluctuations in 1999 (91 percent) and in 2001 (89 percent) are not significantly different from time to time when considering the confidence intervals associated with sample data. CDC will continue to analyze these data and evaluate the policies, programs, and strategies in place to continuously improve the effectiveness of school-based

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HIV/AIDS prevention education. This measure is being moved to a new youth and adolescent health goal developed in the PART process.

**Goal 7, Performance Measure 2:**

CDC continues to review, analyze, and discuss the possible reasons for not reaching the FY 2003 targets for all adolescents adolescents, in consultation with CDC's funded states, cities, and national nongovernmental organizations, and will make programmatic adjustments as needed to improve program effectiveness required to reach the stated targets. Data are released biennially. CDC now requires funded education agencies to complete program performance indicators. The performance indicators will enable CDC to better target technical assistance and assist states in determining priorities. This measure is being moved to a new youth and adolescent health goal developed in the PART process.

*REACH 2010*

<b>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.</b>			
<b>Measure</b>	<b>FY</b>	<b>Target</b>	<b>Result</b>
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.	2006	Convene annual meeting of grantees to review and describe strategies developed to date. Disseminate promising strategies (recommendations) for the elimination of health disparities.	Yes (Met)
	2003	Baseline	Grantee meetings held in December 2003, June and October 2004; Dissemination of strategies began in July 2004
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.	2006	REACH 2010 Risk Factor Survey data (quantitative) on changes in risk/protective behaviors will be collected and disseminated in <u>100%</u> of the communities with health priority areas in breast and cervical cancer, cardiovascular diseases, and diabetes, (excluding the REACH Elderly projects); <u>85%</u> of REACH 2010 communities will collect and disseminate data (qualitative).	10/2007
	2005	Same as above	100%/85% (Met)
	2004	REACH 2010 Risk Factor Survey data (quantitative) on changes in risk/protective behaviors will be collected and disseminated in <u>100%</u> of the communities with health priority areas in breast and cervical cancer, cardiovascular diseases, and diabetes, (excluding the REACH Elderly projects); <u>60%</u> of REACH 2010 communities will collect and disseminate data (qualitative).	100%/60% (Met)

**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.**

**Data Source:** REACH 2010 Risk Factor Survey.

**Data Validation:** Data is delivered to CDC every six months. Data is checked for missing values, outliers, unreasonable values, and illogical values by the contractor during the data collection process and at CDC after data have been delivered.

**Cross Reference:** Measure 1 - HHS-1, 3, HP-3.3, 3.4, 5, 12, 13, 14, 16.1, 500-1; Measure 2 - HHS-3, 4, 500-1, 3

**Goal 8, Performance Measure 1:**

CDC continues to work towards the development of national strategies (recommendations) for eliminating gaps in each of the six health priority areas based on the interventions and findings from the REACH 2010 Projects.

The dissemination of the most promising strategies and of lessons learned is critical to the overall effectiveness of this project. Preliminary measures have been taken to assess the dissemination strategies used by other programs at CDC. Partners that are critical in developing the dissemination plan include the funded communities, evaluation experts, external consultants, private partners, and other federal agencies. Grantee meetings were held in October 2005 and June 2006. In FY 2006, the grantee technical assistance and evaluation workshop attendees rotated in six workgroups to share and begin to synthesize results from their evidence-based and practice-based work. Dissemination work includes the REACH video Success Stories from Our Communities, which will serve as a mechanism to share lessons learned from the REACH program that can be applied by community leaders, public health and community services professionals, faith-based communities, and policy makers to reduce and eliminate health disparities that exist within their communities. In addition, special issues of three scientific journals focusing on the REACH 2010 findings were published: Journal of Health Care for the Poor and Underserved (May 2006), Preventing Chronic Disease (July 2006), and Health Promotion Practice (July 2006).

Now that the data for FY 2006 have been reported, the measure is retired and will not be reflected in future performance detail.

**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.

Between FY 2002 and FY 2005, the REACH 2010 Risk Factor Surveys were conducted in the 27 of the 40 REACH communities in which the health priority areas are breast and cervical cancer, cardiovascular disease, and diabetes. Communities that are focusing on cardiovascular disease and/or diabetes show that the proportion of Hispanics having cholesterol checks increased by 40 percent as compared to a small decline in the general U.S. population; the proportion of hypertensive American Indians on medication increased by ten percent compared to a six percent increase nationally; cigarette smoking among Asian American men decreased by more than 30 percent versus a six percent decline nationally, and the proportion of African Americans that have had their cholesterol checked increased compared to a small decline nationally.

The results of this data collection were disseminated to these 27 communities at the REACH 2010 Technical Assistant Workshop (October 3-5, 2005). The CD-ROMs which contain the combined four-year data and support documents were also distributed to grantees.

In addition, CDC has collected and disseminated qualitative data related to three stages of the REACH 2010 Evaluation Logic Model: (1) community capacity-building activities, (2) intervention strategies, and (3) systems change, and change among change agents. Information was collected through an internet-based data warehousing application called the REACH Information Network (REACH IN). REACH grantees use the system to document current resources, identify specific needs, and document efforts and outcomes. The system allows funded communities and CDC to monitor indicator outcomes related to specific health priority areas.

Eighty-five percent of REACH 2010 communities have collected qualitative data in the REACH IN system for dissemination. This measure will be retired after data are reported for FY 2006.

NEW GOALS AND MEASURES

CANCER

GOAL 1: REDUCE DEATH AND DISABILITY DUE TO CANCER .			
Measure	FY	Target	Result
1. Reduce the age-adjusted annual rate of breast cancer mortality per 100,000 female population. [O]	2015	21.3	2/2017
	1999	Baseline	26.6
2. Increase the percentage of women age 40+ who have had a mammogram within the previous two years. [O]	2008	77%	2/2010
	2004	Baseline	74.6%
3. Decrease the age-adjusted rate of invasive cervical cancer per 100,000 women ages 20+ screened through the NBCCEDP (excludes invasive cervical cancer diagnosed on the initial program screen). [O]	2008	14	2/2010
	2007	14	2/2009
	2004	Baseline	17
<b>Data Source:</b> <u>Measure 1</u> - National Vital Statistics System, NCHS <u>Measure 2</u> - Behavioral Risk Factor Surveillance System (BRFSS) <u>Measure 3</u> – National Breast and Cervical Cancer Early Detection Program (NBCCEDP) Minimum Data Elements (MDE)			
<b>Data Validation:</b> Measure 1 -- Data from the NCHS, a nationally recognized public health information source, undergo statistical computation by the Data Analysis Support Team within CDC's Division of Cancer Prevention and Control to prepare measures based on definitions used within the cancer community. Measure 2 -- BRFSS is a state-based health survey system. Data are submitted to CDC on a monthly basis, where the data undergo rigorous quality checks. CDC also verifies performance through quarterly state reports and periodic site visits. Measure 3 – Grantees submit MDEs electronically to a data management contractor, who analyzes data and submits it to CDC. All data have indicators to assess completeness. Data are also assessed against established clinical standards.			
<b>Cross Reference:</b> <u>Measure 1</u> – HHS 1, 6 ; HP-3.3; 500-3; PART; <u>Measure 2</u> - HHS 1,6 ; HP-3-13; 500- 1,3; PART; <u>Measure 3</u> – HHS-1, 6; HP-3.4, 500-1,3; PART			

**Goal 1, Performance Measure 1:**

Cancer is the second leading cause of death among all Americans, and breast cancer accounts for about 15 percent of cancer deaths among women. The program's National Breast and Cervical Cancer Early Detection Program (NBCCEDP), developed in response to The National Breast and Cervical Cancer Mortality Prevention Act of 1990, contributes to the achievement of this mission by improving access to and the quality of breast and cervical cancer screening and early detection services nationwide.

Breast cancer mortality is declining steadily while incidence is increasing slightly. The decline in mortality is attributable in approximately equal parts to earlier detection through mammography screening and improved treatment. Consequently, continued increases in mammography should contribute to a continue decrease in mortality.

**Goal 1, Performance Measure 2:**

Timely mammography screening among women aged 40 years or older is the best available method to detect breast cancer in its earliest, most treatable stage, and could reduce breast cancer mortality by approximately 16 percent to 30 percent compared with women who are not screened.

Based on annual rates of increase in the 1990's, and the recent leveling-off of the increase in mammography use since the late 1990's, these projected increases would be challenging, yet achievable.

**Goal 1, Performance Measure 3:**

Cancer is the second leading cause of death among all Americans, and cervical cancer accounts for about 1.5 percent of cancer deaths among women. Sixty percent of the invasive cervical cancer diagnosed in this country is found among women who have never been screened, or have not been screened in the last five years.

Deaths from this disease occur disproportionately among women who are uninsured or underinsured. NBCCEDP helps low-income, uninsured, and under-served women gain access to lifesaving screening programs for the early detection of breast and cervical cancers and precancerous lesions. Pap tests funded by the NBCCEDP can find cervical cancer at an early stage when it is most curable or even prevent the disease if precancerous lesions found during the test are treated.

PERFORMANCE DETAIL  
HEALTH PROMOTION  
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According to trend data from the National Cancer Institute's Surveillance, Epidemiology, and End Results Program (SEER) 1992-2002, the rate of invasive cervical cancer for all races combined was declining 2.8 percent per year; rates were significantly declining for white, black, Asian and Pacific Islander, American Indian/Alaska Native, and Hispanic women.

#### TOBACCO

GOAL 2: REDUCE DEATH AND DISABILITY AMONG ADULTS DUE TO TOBACCO USE.			
Measure	FY	Target	Result
1. Reduce the age-adjusted annual rate of trachea, bronchus, and lung cancer mortality per 100,000 population. [O]	2010	43.3	6/2012
	2003	Baseline	54.1
2. Reduce per capita cigarette consumption in the U.S. per adult age 18+. [O]	2008	1,525	6/2010
	2007	1,599	6/2009
	2004	Baseline	1770
<b>Data Source:</b> <a href="#">Measure 1</a> - National Vital Statistics System, NCHS <a href="#">Measure 2</a> - USDA, Economic Research Service, Tobacco Outlook Reports (TBS-259 Sep 2005, Table 2).			
<b>Data Validation:</b> <a href="#">Measures 1</a> - Data are validated by NCHS. <a href="#">Measure 2</a> -- The USDA Economic Research Service updates Tobacco Outlook Reports twice a year. Data quality checks ensure updated census population estimates are incorporated into per capita consumption estimates.			
<b>Cross Reference:</b> <a href="#">Measure 1</a> - HHS - 1, 6; HP 3-2; 500-3; PART; <a href="#">Measure 2</a> - HHS- 1, 6; HP 27-1; 500- 1,3; PART			

#### Goal 2, Performance Measure 1:

Cancer is the second leading cause of death among all Americans, and lung, trachea, and bronchus cancers account for 13 percent of all cancer diagnoses and 29 percent of all cancer deaths. Since 1964, the U.S. Surgeon General's reports on smoking and health have concluded that smoking is a primary cause of lung cancer, and since 1986 have concluded that exposure to secondhand smoke causes lung cancer in nonsmokers. Prior to the baseline year of 2003, mortality rates from lung cancer were decreasing steadily.

#### Goal 2, Performance Measure 2:

Since 1964, the U.S. Surgeon General's reports on smoking and health have concluded that smoking is a primary cause of lung cancer. National trends in per capita cigarette consumption are strongly correlated with national trends in lung cancer mortality rates and consumption trends are recommended as a primary surveillance indicator for lung cancer control efforts. Historical data shows a downward trend in this measure.

#### DIABETES

GOAL 3: PREVENT DIABETES AND ITS COMPLICATIONS.			
Measure	FY	Target	Result
1. Maintain the age-adjusted rate of incidence of End-Stage Renal Disease (ESRD) per 100,000 diabetic population at no higher than its current rate. [O]	2010	231.7	12/2011
	2002	Baseline	231.7
2. Increase the age-adjusted percentage of persons with diabetes age 18+ who receive an A1C test at least two times per year. [O]	2008	73%	12/2009
	2007	72%	12/2008
	2003-2004	Baseline	68.8%
<b>Data Source:</b> <a href="#">Measure 1</a> - US Renal Data System; <a href="#">Measure 2</a> - Behavioral Risk Factor Surveillance System (BRFSS)			
<b>Data Validation:</b> <a href="#">Measure 1</a> - The USRDS is under the administrative oversight of the National Institutes of Health and the Centers for Medicare and Medicaid Services, whose Steering Committee's responsibilities include data validation. <a href="#">Measure 2</a> -- BRFSS is a state-based health survey system. Data are submitted to CDC on a monthly basis, where the data undergo rigorous quality checks. CDC also verifies performance through quarterly state reports and periodic site visits.			
<b>Cross Reference:</b> <a href="#">Measure 1</a> - HHS-1, 6; 500-1,3; PART; <a href="#">Measure 2</a> - HHS-1, 6;HP 5-12; 500-1,3; PART			

**Goal 3, Performance Measure 1:**

End Stage Renal Disease (ESRD) is a complicated and disabling condition and one of the most expensive conditions for which the federal government provides financial coverage. Diabetes mellitus is presently the most common cause of ESRD in the U.S., accounting for approximately 45 percent to 50 percent of all cases of ESRD.

For decades, ESRD incidence was increasing. Since the late 1990's, the rates have declined. As those with diabetes live longer, the incidence of ESRD is likely to increase. Therefore, CDC aims to maintain the current baseline rate.

**Goal 3, Performance Measure 2:**

End Stage Renal Disease (ESRD) is a complicated and disabling condition and one of the most expensive conditions for which the federal government provides financial coverage. Glucose control is one important pathophysiologic factor in the genesis of ESRD. As A1C measurement is the best indicator of glucose control, the annual measure of A1C relates closely to the likelihood of achieving the long-term measure of controlling the rate of ESRD among persons with diabetes.

CDC aims to increase the age-adjusted proportion of persons with diabetes who receive two or more A1C tests by 1 percentage point every year.

*HEART DISEASE AND STROKE*

<b>GOAL 4: REDUCE DEATH AND DISABILITY DUE TO HEART DISEASE AND STROKE .</b>			
<b>Measure</b>	<b>FY</b>	<b>Target</b>	<b>Result</b>
1. Reduce the age-adjusted annual rate per 100,000 population of coronary heart-disease and stroke-related deaths. [O]	2015	CHD: 166 Stroke: 50	12/2017
	2002	Baseline	CHD: 187 Stroke: 61
2. Increase the age-adjusted proportion of persons age 18+ with high blood pressure who have it controlled (<140/90). [O]	2007-2008	<b>50%</b>	12/2010
	2005-2006	41%	12/2008
	2003-2004	40%	2/2007
	1999-2002	Baseline	32%
3. Maintain the age-adjusted proportion of persons age 20+ with high total cholesterol ( $\geq 240\text{mg/dL}$ ) at no higher than its current rate. [O]	2007-2008	17%	12/2010
	2005-2006	17%	12/2008
	2003-2004	17%	2/2007
	1999-2002	Baseline	17%
<b>Data Source:</b> <u>Measure 1</u> - National Vital Statistics System, NCHS <u>Measure 2</u> - National Health and Nutrition Examination Survey (NHANES) <u>Measure 3</u> - NHANES			
<b>Data Validation:</b> <u>Measures 1 - 3</u> - Data are validated by NCHS.			
<b>Cross Reference:</b> Measure 1 – HHS- 1, 6; HP 12-1; 500-3; PART <u>Measure 2</u> – HHS – 1, 6; HP 12-10; 500-1, 3; PART <u>Measure 3</u> – HHS- 1, 6 ; HP 12-14; 500-1,3; PART			

**Goal 4, Performance Measure 1:**

Currently, Coronary Heart Disease (CHD) is the single largest killer of Americans, causing one of every five deaths in the U.S. in 2003. It is estimated that 700,000 Americans will have a new coronary attack and about 500,000 will have a recurrent attack. Stroke ranks number three among all causes of death, accounting for about one of every 15 deaths in the U.S. in 2003. Each year about 700,000 people experience a new or recurrent stroke.

CHD death rates have been decreasing steadily since 1995. Stroke rates have been fairly stable since 1998.

**Goal 4, Performance Measure 2:**

Hypertension affects approximately 65 million adults (nearly one in three) in the U.S. and is the most common primary diagnosis in America. The relationship between blood pressure and the risk of CVD events is consistent and independent of other factors. The higher the blood pressure, the greater is the chance of heart attack, heart failure,

stroke, and kidney disease. About 69 percent of people who have a first heart attack, 77 percent who have a first stroke, and 74 percent who have congestive heart failure have hypertension.

Prior to 2000, data for this measure was collected sporadically. In order to reach the target, high blood pressure control should increase by approximately 4.5 percentage points per year. Annual targets reflect that increase.

#### **Goal 4, Performance Measure 3:**

Approximately 38 million American adults have blood cholesterol levels of 240 mg/dL or higher, which is considered high risk. Lowering cholesterol can reduce the risk for developing heart disease, including heart attacks, and, among those with heart disease, the need for heart bypass surgery or angioplasty. Recent studies show that high levels of LDL ("bad" cholesterol) and triglycerides increase the risk of stroke in people with previous coronary heart disease, ischemic stroke or transient ischemic attacks (TIAs). Low levels of HDL ("good" cholesterol) may also raise stroke risk.

Although the objective of 17 percent was reached during 1999-2002, the estimate is expected to increase with the emerging epidemic of obesity. The annual targets reflect maintenance at the current level.

#### *NUTRITION AND PHYSICAL ACTIVITY*

<b>GOAL 5: REDUCE THE RATE OF GROWTH OF OBESITY THROUGH NUTRITION AND PHYSICAL ACTIVITY INTERVENTIONS.</b>			
<b>Measure</b>	<b>FY</b>	<b>Target</b>	<b>Result</b>
1. Reduce the age-adjusted percentage of adults age 18+ who engage in no leisure-time physical activity. [O]	2014	21.5%	12/2015
	2004	Baseline	24.36%
2. Slow the estimated average age-adjusted annual rate of increase in obesity rates among adults age 18+. [O]	2010-2014	+0.16 average increase per year	12/2015
	2002-2004	Baseline	+0.64 average increase per year

**Data Source:** Measures 1 and 2 - Behavioral Risk Factor Surveillance System (BRFSS)

**Data Validation:** Measures 1 and 2 – BRFSS is a state-based health survey system. Data are submitted to CDC on a monthly basis, where the data undergo rigorous data quality checks. CDC also verifies performance through quarterly state reports and periodic site visits.

**Cross Reference:** Measure 1 - HHS- 1, 6; HP 22-1; 500- 1,3; PART Measure 2 - HHS- 1, 6 ; HP 19-2; 500- 1, 3; PART

#### **Goal 5, Performance Measure 1:**

Major causes of morbidity and mortality in the U.S. are related to physical inactivity and poor diet. In particular, cardiovascular disease, type 2 diabetes, hypertension, and certain cancers are linked to poor diet and a sedentary lifestyle.

There has been an absolute decline from 29 percent to 24 percent in the past ten years. Rate of decrease is expected to lessen over the next ten years.

#### **Goal 5, Performance Measure 2:**

About 60 million adults, or 30 percent of the adult population, are now obese. Obesity is related to two-thirds of diabetes cases and of heart disease cases, 20 percent of cancers in women and 15 percent of cancers in men. Additionally, it causes or exacerbates many other serious chronic diseases and conditions, including hypertension and stroke.

Rates of obesity have been increasing at the rate of approximately 0.64 percentage points per year during the years 2002 through 2004. CDC aims to slow the rate of growth in obesity rates.

**YOUTH AND ADOLESCENT HEALTH**

<b>GOAL 6: IMPROVE YOUTH AND ADOLESCENT HEALTH BY HELPING COMMUNITIES CREATE AN ENVIRONMENT THAT FOSTERS A CULTURE OF WELLNESS AND ENCOURAGES HEALTHY CHOICES .</b>			
<b>Measure</b>	<b>FY</b>	<b>Target</b>	<b>Result</b>
1. Achieve and maintain the percentage of high school students who are taught about HIV/AIDS prevention in school at 90% or greater. [O]	2009	90%	6/2010
	2007	90%	6/2008
	2005	Baseline	87.9%
2. Increase the proportion of adolescents (grades 9-12) who abstain from sexual intercourse or use condoms if currently sexually active. [O]	2009	89%	6/2010
	2007	89%	6/2008
	2005	Baseline	87.5%
3. Reduce the proportion of children aged 3 to 11 who are exposed to second-hand smoke. [O]	2008	45%	12/2010
	2007	45%	12/2009
	2001-2002	Baseline	55%
4. Percentage of youth (grades 9-12) who were active for at least 60 minutes per day for at least five of the preceding seven days. [O]	2009	35.8%	6/2010
	2007	35.8%	6/2008
	2005	Baseline	35.8%

**Data Source:** Measure 1 - Youth Risk Behavior Surveillance System (YRBSS) Measure 2 - YRBSS Measure 3 – NHANES Measure 4 - YRBSS

**Data Validation:** Measures 1, 2 and 4: Validity and reliability studies of YRBSS attest to the quality of the data. CDC conducts quality control checks and logical edit checks on each record. Measure 3 – Data are validated by NCHS.

**Cross Reference:** Measure 1 - HHS - 1 ; HP 7-2; 500- 1,3, 5, 6 Measure 2 – HHS - 1; HP 25-11; 500 -1, 3, 5, 6 Measure 3 – HHS -1, 7 ; HP 27-10; 500-1, 3; PART Measure 4 - HHS-1, 500-1,3; PART

**Goal 6, Performance Measure 1:**

In 2004, an estimated 7,761 young people were living with AIDS, a 42 percent increase since 2000, and an estimated 3,867 young people received a diagnosis of HIV/AIDS, representing about 12 percent of the persons given a diagnosis during that year. Young men who have sex with men, especially those of minority races or ethnicities, were at high risk for HIV infection.

**Goal 6, Performance Measure 2:**

Each year there are approximately 19 million new STD infections in the U.S. and almost half of them are among youth ages 15 to 24. Thirty-four percent of young women – approximately 820,000 each year – become pregnant at least once before the age of 20. Data from the 2005 Youth Risk Behavior Survey (YRBS) show that 47 percent of high school students had had sexual intercourse, Fourteen percent of high school students had four or more sex partners during their lifetime, and 37 percent of sexually active high school students did not use a condom at last intercourse. STDs (including HIV) among youth result in substantial economic burden to our society. The total estimated burden of the nine million new cases of STDs that occurred among 15 to 24-year-olds in 2000 was \$6.5 billion (in year 2000 dollars).

**Goal 6, Performance Measure 3:**

Cancer is the second leading cause of death among all Americans, and lung, trachea, and bronchus cancers account for 13 percent of all cancer diagnoses and 29 percent of all cancer deaths. Secondhand smoke, also known as environmental tobacco smoke (ETS), has been determined to be a known human carcinogen. Persistent exposure to ETS is associated with an increased risk for lung cancer. Since 1986, the U.S. Surgeon General's reports have concluded that exposure to secondhand smoke causes lung cancer in nonsmokers.

The program provides national leadership for a comprehensive, broad-based approach to reducing tobacco use which involves: preventing young people from starting to smoke; eliminating exposure to secondhand smoke; promoting quitting; and, identifying and eliminating disparities in tobacco use among population groups. It also develops health communication campaigns aimed at informing the public about the health risks associated with environmental tobacco smoke and reducing disparities in these exposures.

Prior to the baseline time period, this measure was declining steadily, with significant progress between the end of NHANES III (1988-1994) and the most recent NHANES (1999-2002).

**Goal 6, Performance Measure 4:**

Increased physical activity—whether through structured (e.g., organized recreation or sports) or unstructured (e.g., recess, free play) opportunities—helps reduce the risk of chronic diseases and prevent excess weight gain among children and adolescents. Physical activity is a critical component of obesity prevention efforts, as those adolescents who are already overweight are at an increased risk --70 percent chance--of becoming overweight and obese adults. Chronic diseases and obesity in adulthood are even more likely if overweight existed in adolescence, thereby increasing the likelihood of adults suffering from multiple comorbidities, such as heart disease, type 2 diabetes, and certain types of cancer.

Prior to the baseline year, this data was not collected by the YRBSS. The guideline for this measure was developed and published in the baseline year.

### **BIRTH DEFECTS, DEVELOPMENTAL DISABILITIES, DISABILITY AND HEALTH**

The Birth Defects and Developmental Disabilities program underwent OMB's Program Assessment Rating Tool (PART) process in 2006 in preparation for the FY 2008 President's Budget. As a result, several of the performance budget measures have been changed or retired, while new measures approved through the PART process have been added.

Efficiency Measure	FY	Target	Result
1. Establish an ongoing data management center for developmental disabilities monitoring and research sites, resulting in savings of program staff time. [E]	2005	Establish data center	Yes (Met)
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]	2006	250	12/2007
3. Increase the percent of competitive (new) cooperative agreements/grants that are processed in less than or equal to 176 days (excluding extramural research). [E]	2008	91%	2/2009
	2007	82%	2/2008
	2006	73%	2/2007
	2005	Baseline	64%
<b>Data Source:</b> <u>Measures 1 and 2</u> - Data Coordinating Center for Autism and Developmental Disabilities Surveillance and Epidemiologic Research; <u>Measure 3</u> - National Center on Birth Defects and Developmental Disabilities Extramural Program Management Information System (EPMIS).			
<b>Data Validation:</b> Measures 1 and 2 - Once software is operational and collaborative autism research study is underway, staff will be able to retrieve and report the number of autism cases entered into database. Measure 3 - Staff will use current software to track the number of days from delivery of funding package to actual award of resources to grantee.			
<b>Cross Reference:</b> <u>Measure 1</u> - HHS-8, HP-16.14, 500-1; <u>Measure 2</u> - HHS-8, HP-16.14, 500-1; <u>Measure 3</u> - HHS-16, HP-16.14, 500-1, PART			

#### **Efficiency Measure 1:**

CDC supports Centers for Autism and Developmental Disabilities Research and Epidemiology in six states. These Centers (including CDC's own model tracking program in Atlanta) track autism and other developmental disabilities and conduct public health research into the causes of autism. These efforts are essential for CDC to fulfill its Congressional mandate to collect, analyze, and disseminate autism data. The successful establishment of an ongoing data management center for these sites has resulted in significant time savings. Now that the data for FY 2005 have been reported, the measure is retired and will not be reflected in future performance detail.

#### **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 Data Coordinating Center, thus saving program and staff time and expediting efforts to understand the prevalence and causes of autism. This measure will be retired after data are reported for FY 2006.

#### **Efficiency Measure 3:**

In FY 2005, CDC spent over 60 percent of its budget on cooperative agreements and grants. Because awarding of cooperative agreements and grants involves a 25 step process, executing the award process efficiently and accurately is of critical importance. Increased accuracy and timeliness of the awarding process will allow grantees to optimize use of funds and increase the probability of fully executed awards during the project period. In addition, the program will save work hours expensed through repetitive processes. Ultimately, the goal of the expeditious disbursement of funds will promote implementation of public health interventions designed to improve the nation's health. In FY 2005 (baseline), 64 percent of new competitive cooperative agreements/grants were processed within the target of 176 days.

**PERFORMANCE DETAIL**  
**HEALTH PROMOTION**  
**BIRTH DEFECTS, DEVELOPMENTAL DISABILITIES, DISABILITY AND HEALTH**

**GOAL 1: PREVENT BIRTH DEFECTS AND DEVELOPMENTAL DISABILITIES.**

<b>Measure</b>	<b>FY</b>	<b>Target</b>	<b>Result</b>
1. Decrease the percentage of women who report any alcohol consumption during pregnancy. [O]	2006	8.0%	12/2008
	2005	8.5%	12/2007
	2004	10.0%	10.8% (Unmet)
	2003	11.5%	10.6 % (Exceeded)
	1999	Baseline	12.8%
2. Reduce by 1% per year the number of children born with spina bifida and anencephaly through promotion of folic acid consumption by women of reproductive age. [O]	2006	4% reduction	12/2009
	2005	3% reduction	12/2008
	2004	2% reduction	12/2007
	2003	1% reduction	2,021 (Unmet)
	2000	Baseline	1,932
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.	2006	2,900,000	2,860,134 (Unmet)
	2005	2,800,000	2,803,301 (Exceeded)
	2004	2,700,000	2,644,925 (Unmet)
	2003	2,600,000	2,609,477 (Exceeded)
4. Increase the sensitivity of birth defects and developmental disabilities monitoring data. [O]	2008	<b>Birth Defects- Improve by 1% /Developmental Disabilities- Data analyses and preliminary results</b>	12/2008
	2007	Birth Defects- Establish Baseline/Developmental Disabilities- Enroll remaining eligible sample	12/2007
	2006	Developmental Disabilities- Enroll 40-50% of eligible sample	Yes (Met)
	2005	Developmental Disabilities- Initiate validation study	Yes (Met)
5. Identify and evaluate the role of at least five new factors for birth defects and developmental disabilities.	2008	<b>Publish findings on maternal medications</b>	12/2008
	2007	Publish findings on alcohol, caffeine use, and nutrition	12/2007
	2006	Finalize research agenda for birth defects and publish findings on smoking, obesity, and other exposures with high potential impact	Yes (Met)
	2005	Establish large statistically powerful sample for birth defects research	Yes (Met)
6. Reduce health disparities in the occurrence of folic acid-preventable spina bifida and anencephaly by reducing the birth prevalence of these conditions among Hispanics. [O]	2008	<b>4.8</b>	12/2011
	2007	4.9	12/2010
	2006	5.0	12/2009
	2005	5.1	12/2008
	2004	5.3	12/2007
	2003	5.4	6.4/10,000 (Unmet)
	2000	Baseline	6.2/10,000

<b>GOAL 1: PREVENT BIRTH DEFECTS AND DEVELOPMENTAL DISABILITIES.</b>			
<b>Measure</b>	<b>FY</b>	<b>Target</b>	<b>Result</b>
7. Increase the percentage of health providers who screen women of childbearing age for risk of an alcohol-exposed pregnancy and provide appropriate, evidence-based interventions for those at risk. [O]	2008	Implement ongoing provider education programs and establish baseline rates of provider-based screening and intervention.	12/2008
	2007	Assess the screening and intervention practices of nationally representative samples of provider groups.	12/2007
	2006	Develop and disseminate screening and intervention tools for health care providers serving women of childbearing age.	Yes (Met)
	2005	Complete randomized control trial determining effectiveness of provider-based interventions for preconceptional women who are at risk for an alcohol-exposed pregnancy.	Yes (Met)
	2004	Publish targeted recommendations for provider-based screening and intervention.	Yes (Met)
	2003	Publish study assessing feasibility of provider-based interventions targeting women at high risk for alcohol-exposed pregnancy.	Yes (Met)
<b>Data Source:</b> Measure 1 - Data are from CDC's Behavioral Risk Factor Surveillance System (BRFSS). Measure 2 - Data are from the National Birth Defects Prevention Network (NBDPN). Measure 3 - Data are from the Developmental Disabilities Data Coordinating Center. Measure 4 – Metropolitan Atlanta Congenital Defects Program (MACDP) and the Metropolitan Atlanta Developmental Disabilities Surveillance Program (MADDSP). Measures 5 and 6 – NBDPN. Measure 7 – Data are from Project CHOICES, a CDC-funded randomized control trial regarding provider-based interventions for preconceptional women who are at risk for an alcohol-exposed pregnancy.			
<b>Data Validation:</b> Measure 1 - BRFSS data are collected each month and from every state, D.C., and 3 U.S. territories through a random-digit-dialed telephone survey. In addition to providing training and technical assistance, CDC staff produce monthly and annual quality assurance reports. Measure 2 - Prevalence data obtained from eight population-based surveillance systems in the NBDPN. Due to ongoing data collection with more recent years less likely to be complete, reporting lags are utilized to ensure more complete data. Denominator data are based on the number of live births reported by CDC's National Center for Health Statistics. Measure 3 - As part of the NBDPN, all data are updated annually. In addition, states conduct three validation checks in conjunction with CDC prior to publication of the identified data. Measure 4 – Data from the CDC-based model birth defects surveillance system are updated annually. Measure 5 – Publications are made possible as a result of analyses of NBDPN pooled data sets. Measure 6 – Data from NBDPN are used to measure rates of spina bifida and anencephaly among Hispanics. Measure 7 – Results of the randomized control trial (2005 target) published in a peer-reviewed journal.			
<b>Cross Reference:</b> Measure 1 - HHS-1, HP-16.17, 500-1; Measure 2 - HHS-5, HP-16.15-16, 500-1; Measure 3 - HHS-4, HP-16.15, 500-1; Measure 4 – HHS-4, HP-16.1f, HP-16.14, 500-1, PART; Measure 5 – HHS-4, HP 16.1f, HP-16.14, 500-3, PART; Measure 6 – HHS-1, HHS-3, HP-16.15, HP-16.16, 500-1, PART; Measure 7 – HHS-1.4, HHS-3, HP-16.17, HP-16.18, 500-1, PART			

#### **Goal 1, Performance Measure 1:**

CDC funds programs designed to build statewide capacity in Fetal Alcohol Syndrome (FAS) prevention and monitoring; a collaborative research consortium for identifying, developing, and evaluating effective strategies for intervening with children and/or adolescents with FAS and related conditions; research programs to identify and test new FAS prevention and management methods; regional training centers to increase health care providers' knowledge about how to present FAS; and education materials for parents, educators and social service providers about accessing appropriate diagnostic and treatment services for affected children and their families. In addition, CDC provides support to all 50 states to monitor alcohol consumption levels, and support targeted outreach to Cherokee nation. CDC met and exceeded the FY 2003 target, with 10.6 percent of women reporting alcohol consumption during pregnancy. However, in FY 2004, the target was not met. CDC is implementing a recently-proven successful intervention to reach high-risk women. CDC anticipates that this intervention will contribute to reducing rates of alcohol consumption during pregnancy. This measure will be retired after data are reported for FY 2006.

**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 neural tube 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. CDC published data documenting the effectiveness of folic acid fortification in preventing spina bifida and anencephaly. Data from birth defects monitoring programs showed that, as a result of fortification, approximately 1,000 more babies are born without these defects each year. Data show the number of children born with these defects were 1,709 in 2002, an 11.5 percent decrease from the 2000 baseline of 1,932. Data from 2003, however, show the number of cases increasing to 2,021, leaving this target unmet for this year. While an increase from one year to the next does not necessarily mean a reversal in the trend of declining rates, CDC has published an analysis documenting declining levels of blood folate among women of childbearing age. It is unclear of the exact reason for the decline (however, popularity of low carbohydrate diets may contribute) but decreased consumption of folic acid would negatively affect rates of folic acid-preventable birth defects. This measure will be retired after data are reported for FY 2006.

**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. 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 information about risk factors and causes of birth defects. CDC publishes data from the monitoring programs in its annual congenital malformations report. In FY 2006, CDC worked to increase the number of births covered by birth defects monitoring programs by guiding and funding states to build and strengthen birth defects surveillance systems. While the number of births did increase in FY 2006, the target was not met. CDC will continue to fund state birth defects surveillance programs which support the NBDPN, a collaboration of individuals working at the local, state and national levels in birth defects surveillance, research and prevention. Now that the data for FY 2006 have been reported, the measure is retired and will not be reflected in future performance detail.

**Goal 1, Performance Measure 4:**

This measure was developed through the 2006 PART process.

Because the birth defects system is more mature and able to be assessed numerically, investments in the developmental disabilities systems are needed to measure the same level (a study was developed in 2004 and initiated in 2005). However, the model for the birth defects and developmental disabilities surveillance systems is based on the same methodology. CDC projects baseline data will be available by the end of 2007 for Birth Defects and in 2009 for Developmental Disabilities. For birth defects, the target percentage is a measure of sensitivity. For developmental disabilities, the measure is initially based on establishing the baseline probability that a true developmental disability is identified by the program's model system.

**Goal 1, Performance Measure 5:**

This measure was developed through the 2006 PART process.

Understanding the role of modifiable risk and preventive factors in the etiology of birth defects and developmental disabilities provides an important opportunity for prevention. As prior investments in the research infrastructure for birth defects is more mature, initial efforts for annual performance measures focus on publication of research findings from this system. Meanwhile, the infrastructure for research on autism and other developmental disabilities research is being established. This research infrastructure follows the same model as birth defects but is in the early stages of development, with initial publication of findings expected in 2012.

**Goal 1, Performance Measure 6:**

This measure was developed through the 2006 PART process.

Pregnancies and births affected by spina bifida and anencephaly have profound physical, emotional, and financial effects on families and communities. Since food fortification began in 1998, thousands of babies are being born in the U.S. without these serious birth defects. However, analyses by racial and ethnic groups found that while fortification lowered rates significantly among all racial and ethnic groups, a disparity with respect to Hispanics has persisted. CDC is currently focusing on developing and implementing evidence-based strategies to reduce the occurrence of these birth defects among Hispanics. Targets are based on the concept of diminishing returns, the understanding that preventing the earlier cases was easier than preventing the latter cases. For example, in 1996 - 2000, rates declined by 36 percent. As it became increasingly difficult to prevent cases with existing strategies, more intensive efforts were required to achieve the same level of reductions. Thus, for the next five year period (2001-2005), targets were set based on a proposed 18 percent decline in rates (half of 36 percent). Similarly, for the subsequent five years (2006-2010), CDC set targets based on a proposed decline of an additional 9 percent (one-half

of 18 percent) from 2005. Unfortunately, data for 2003 reveal an increase in the rate of these birth defects among the Hispanic population. These data further underscore the importance of targeted efforts to address the high rates among Hispanics. CDC's two priority activities in this area are developing and disseminating targeted campaign materials and working with partners to explore the addition of folic acid to corn flour products.

**Goal 1, Performance Measure 7:**

This measure was developed through the 2006 PART process.

Implementing intervention strategies to reduce alcohol consumption during pregnancy is an important component of reducing the occurrence of alcohol-related birth defects and developmental disabilities, including Fetal Alcohol Syndrome. Research shows that 1) provider-based screening of women of childbearing age at risk of having an alcohol-exposed pregnancy, and 2) provider-based interventions for women at risk are effective strategies for reducing alcohol-exposed pregnancies. CDC has begun to translate research findings through the development and publication of targeted recommendations on provider-based screening and interventions for women of childbearing age. CDC has developed a quick-reference clinician tool to facilitate screening and interventions among providers. As of December, 2006, over 4,000 toolkits have been disseminated. Through education about and implementation of this tool, CDC aims to improve the percentage of health care providers who screen women of childbearing age for risk of alcohol-exposed pregnancy and provide appropriate interventions for those at risk.

<b>GOAL 2: IMPROVE THE HEALTH AND QUALITY OF LIFE OF AMERICANS WITH DISABILITIES.</b>			
<b>Measure</b>	<b>FY</b>	<b>Target</b>	<b>Result</b>
1. By 2010, decrease to 10% the percentage of newborns that screen positive for hearing loss but are lost to follow-up. [O]	2006	22%	12/2008
	2005	25%	12/2007
	2004	30%	23% (Exceeded)
	2003	35%	31% (Exceeded)
	2002	Baseline	36.6%
2. Decrease the overall health disparity experienced by people with disability by increasing the number of states that implement a health promotion program to improve the health and quality of life for persons with disabilities.	2006	20	29 (Exceeded)
	2005	8	27 (Exceeded)
	2004	7	25 (Exceeded)
	2003	6	17 (Exceeded)
3. Increase the number of people with blood disorders who participate in the monitoring system by 10%. [O]	2008	<b>18,948</b>	12/2008
	2007	18,590	12/2007
	2006	18,232	19,889 (Exceeded)
	2005	Baseline	17,874
4. Identify an effective public health intervention to ameliorate the effects of poverty on the health and well-being of children. [O]	2008	<b>Data collection and analysis for age 3 year</b>	12/2008
	2007	Data collection and analysis for age 2 year	12/2007
	2006	Data collection and analysis for age 1 year	Yes (Met)
	2005	Data collection and analysis for age 6 months	Yes (Met)
	2004	Baseline data collection	Yes (Met)
	2002	Initiate main study	Yes (Met)
5. Ensure that 95% of all infants are screened for hearing loss by 1 month of age. [O]	2008	<b>93%</b>	12/2010
	2007	92%	12/2009
	2006	91%	12/2008
	2005	90%	12/2007
	2004	89%	92% (Exceeded)
	2003	Baseline	88%

<b>GOAL 2: IMPROVE THE HEALTH AND QUALITY OF LIFE OF AMERICANS WITH DISABILITIES.</b>			
<b>Measure</b>	<b>FY</b>	<b>Target</b>	<b>Result</b>
6. Increase the mean lifespan of patients with DBMD and carriers by 10% as measured by the Muscular Dystrophy Surveillance, Tracking and Research Network. [O]	2008	Report on the impact of clinic use on morbidity and mortality in DBMD using MD STARnet data	12/2008
	2007	Identify and report on (1) the incidence and prevalence of DBMD in the United States based on MD STARnet data (2) early signs and symptoms of DBMD based on MD STARnet and (3) cost of health care of people with DBMD.	12/2007
	2006	Conduct data analysis on MD STARnet data collected in the 4 current sites and include one additional state.	Yes (Met)
	2005	Analyze preliminary mortality data associated with DBMD from MD STARnet	Yes (Met)
	2004	Establish a health surveillance system for DBMD in 4 states	Yes (Met)
<p><b>Data Source:</b> <u>Measures 1 and 5</u> - Data are from the University of Montana, Directors of Speech and Hearing Programs for State Health and Welfare Agencies (DSHPSHWA).). Measure 2 – Data are from the University of Montana Rural Institute: Center for Excellence in Disability Education, Research, and Service. <u>Measure 3</u>- Data are from the CDC blood safety Universal Data Collection System. <u>Measure 4</u> – Data provided by the Division of Human Development and Disability's Child Development Studies Team. <u>Measure 6</u> - Data are from MD STARnet.</p> <p><b>Data Validation:</b> <u>Measures 1 and 5</u> - Data obtained from the DSHPSHWA are collected on an annual basis. A survey section is included for states to provide updated data from the previous year. Data are compared at CDC to monitor the quality of data being reported. Additionally, data from the National Center for Health Statistics are used to verify the reported number of live births reported by each EHDI program. <u>Measure 2</u> - CDC verifies the data on an ongoing basis but no less than quarterly by contacting grantees at the University of Montana via phone or e-mail to confirm states where training has taken place for implementing the Living Well With a Disability Program. <u>Measure 3</u> - For those grantees that participate in electronic form submission, the data are updated in real time. For all others CDC verifies the data quarterly. <u>Measure 4</u> - Publications are made possible as a result of analyses of <i>Legacy for Children</i> data. <u>Measure 6</u> - CDC verifies the data on an ongoing basis but no less than quarterly by contacting grantees at MD STARnet sites via phone or e-mail or phone to ensure a high level of quality among surveillance sites.</p> <p><b>Cross Reference:</b> <u>Measure 1</u> - HHS-5, HP-28.11, 500-1; <u>Measure 2</u> - HHS-3, 6, HP-6.1-13, 500-1; <u>Measure 3</u> - HHS-1, PART; <u>Measure 4</u> - HHS-1,7, 500-5; HP 19, 21, 25, 26, 27, PART; <u>Measure 5</u> - HHS-3, 6, HP-6.1-13, 500-1, PART; <u>Measure 6</u> - HHS 3.5, 5, 500-1, PART</p>			

#### **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 targets efforts to measure the impact of the first and second phases in this process to track the number of children initially screened for hearing loss in the hospital and the number evaluated by a trained audiologist to confirm or deny screening results. Even this seemingly small step involves multiple places where children with hearing loss can be “lost to follow-up,” and is essential for the achievement of targets. To help reduce the burden on states and create a central source of data, CDC, in collaboration with key partners, has designed a standardized form to gather aggregate level EHDI-related data, including “lost to follow-up.” In FY 2003, CDC exceeded its target with 31 percent of newborns that screen positive for hearing loss but are lost to follow-up. This measure will be retired after data are reported for FY 2006.

#### **Goal 2, Performance Measure 2:**

CDC supports research and other programs to improve health and quality of life among people of all ages with disabilities. The primary goals of the research component are to identify risk and protective factors, develop effective prevention strategies, and assess the cost-effectiveness of health promotion interventions. One such intervention, “Living Well with a Disability,” has demonstrated its ability to improve health and reduce medical costs. This intervention demonstrates the relationship between CDC-funded research and the translation of this research into public health programs. Now that the data for FY 2006 have been reported, the measure is retired and will not be reflected in future performance detail.

**Goal 2, Performance Measure 3:**

This measure was developed through the 2006 PART process.

CDC employs a Universal Data Collection (UDC) system to monitor blood safety through blood sample testing of individuals seen at a network of Hemophilia Treatment Centers (HTCs) across the country. Blood samples are tested for HIV, Hepatitis A, B and C and other emerging infectious agents as needed. These samples provide a national repository for the testing of emerging infectious diseases to quickly identify blood-borne infections contaminating blood products used to treat bleeding disorders and prevent transmission of infectious diseases. Given that the hemophilia population utilizes more blood products than any other group, the UDC acts as an early warning network for the identification and prevention of transmission of blood borne agents. The UDC also provides information on joint mobility and function, bleeding occurrences, treatment and vaccinations.

**Goal 2, Performance Measure 4:**

This measure was developed through the 2006 PART process.

Development plays a critical role in the biological and behavioral processes that impact health and well-being throughout the lifespan, but has increased importance for immediate and long-term health outcomes during infancy, early childhood, and adolescence. Healthy children are more ready to learn and are more likely to become healthy adults who will be productive members of society. Children who grow up in environments where their developmental needs are not met are at an increased risk for compromised health and safety and learning and developmental delays. In addition, it has been demonstrated that adults who were exposed to four or more adverse childhood events were at higher risk for alcoholism, drug abuse, depression, suicide attempt, smoking, poor self-rated health, multiple sexual partners, sexually transmitted disease, physical inactivity, and obesity. In response, CDC focused on developing an innovative public health intervention to promote protective factors and ameliorate risk factors impacting developmental outcomes. This intervention is currently being tested by a multi-site randomized control trial.

**Goal 2, Performance Measure 5:**

This measure was developed through the 2006 PART process.

CDC's activities to support early hearing detection are important for ensuring timely referral to early intervention for all infants with hearing loss. CDC supports state-based efforts to promote and ensure that all children receive a hearing screening before one month of age. This includes infants born in hospitals as well as those born in community birthing centers, homes, and other settings. There is a two year data reporting lag.

**Goal 2, Performance Measure 6:**

This measure was developed through the 2006 PART process.

In order to achieve this goal, CDC is engaged in the development of a population-based monitoring system designed to ascertain key health information for people with Muscular Dystrophy. This system, MD STARnet, is the only source of epidemiologic data necessary to engage in intervention research. Annual goals are set to document progress towards the health outcome. These benchmarks reflect essential steps in the public health process: public health surveillance, epidemiologic research, and intervention development and delivery.

## HEALTH INFORMATION AND SERVICE

### HEALTH STATISTICS

Health Statistics participated in the PART review for the 2005 cycle. This document reflects measures adopted as a result of the PART process. While they may seem redundant, there are variations in how an outcome is being measured. The PART measures are ambitious and will eventually become a permanent element of this performance plan.

Efficiency Measure	FY	Target	Result
1. Deliver timely data to the nation's health decision-makers. [E]		a) Reduce data release time lags.	N/A
	2006	Reduce time lags for release of core data systems by 5%; National Health Interview Survey (NHIS): Release quarterly 2007 data in 6 months from end of data collection year	Met
	2005	Same as above	Met
	2004	Same as above	Met
	2003	Same as above	Met
		b) Make statistics Internet-accessible.	N/A
	2006	Make health statistics Internet-available, including the development of one new product	Met
	2005	Same as above	Met
	2004	Same as above	Met
	2003	Same as above	Met
		c) Produce publications.	N/A
	2006	Produce reports and publications that document trends, issues, and problems in health.	Met
	2005	Same as above	Met
	2004	Same as above	Met
	2003	Same as above	Met
2. The number of months for release of data as measured by the time from end of data collection to data release on internet. [E,O]	2008	11.9	12/2010
	2007	12.4	12/2009
	2006	12.9	12/2008
	2005	13.5	12/2007
	2004	N/A	13.8
	2003	Baseline	14.5
<b>Data Source:</b> <u>Measure 1</u> - NHIS; <u>Measure 2</u> – National Health and Nutrition Examination Survey (NHANES), National Vital Statistics System (NVSS), NHIS and the National Health Care Survey (NHCS).			
<b>Data Validation:</b> <u>Measure 1</u> - The NHIS provides information annually on the health status of the U.S. civilian non-institutionalized population through confidential interviews conducted in households. Health Statistics has extensive quality control processes to ensure the accuracy of its data. There are many steps during the process of collecting, "cleaning up", and analyzing data that are conducted to ensure that data disseminated are of the highest quality possible. <u>Measure 2</u> - Review internal information on end of data collection and release of data for NHANES, NVSS, NHIS and NHCS.			
<b>Cross Reference:</b> Measure 1- HHS-8, HP-1, 2, 3, 5, 6, 7, 8, 9, 12, 13, 14, 15, 16, 17, 18, 19, 21, 22, 23, 24, 25, 26, 27, 28; <u>Measure 2</u> – PART, HHS-8, HP-1, 2, 3, 5, 6, 7, 8, 9, 12, 13, 14, 15, 16, 17, 18, 19, 21, 22, 23, 24, 25, 27, 28			

**Efficiency Measure 1:**

- a) Reduce data release time lags.

Because the National Health Interview Survey (NHIS) is conducted throughout the year, yielding a nationally representative sample each week, data can be analyzed weekly or quarterly to monitor health insurance coverage trends and other selected estimates. In FY 2006, CDC's NHIS continues to provide the most recent health insurance coverage data, as well as quarterly trend data on selected topics, such as data on usual place to go for medical care, and the prevalence of smoking for adults. Trend data for 2005 were released in June 2006. The microdata release for 2005 occurred one month earlier than last year's release. Trend data for the first half of 2006 (January to June) was released in December 2006.

CDC substituted the Early Release of Selected Estimates from the NHIS as CDC's example for this efficiency measure because it is a more accurate measure of CDC's efforts to improve timeliness, as it represents work done by CDC (rather than work done, in part, by partners outside of CDC's control).

- b) Make statistics Internet accessible.

In FY 2006, CDC continues to achieve improvements in technological advances, such as the use of the Internet to make data more timely and accessible. Virtually all CDC publications are available on the Internet concurrent with their release in published form.

All CDC data are now available, from 1968 to the present, on CD-ROM. CDC also recently made its Web site accessible to visually impaired data users. Other efforts are being made to increase the accessibility and usability of the data systems and website for disabled people.

Internet-only releases, such as Health E-Stats and the Early Release of NHIS (data for the first half of 2006 were released in December 2006) help make CDC's data more accessible to the public. *Health, United States, 2006* was released on line in November and will be mailed to data users in January.

- c) Produce publications.

In FY 2006, CDC continued to lead the efforts to produce *America's Children in Brief* which was released in July 2006. *America's Children in Brief, Key National Indicators of Well-Being, 2006*, released in July 2006. This year the report is a condensed version that highlights selected indicators. The more detailed report will be published in July 2007.

Now that the data for FY 2006 have been reported, the measure is retired and will be replaced by the efficiency measure below.

**Efficiency Measure 2:**

Efficiency measure 2 has been developed through the PART process for the 2005 cycle and is also serving as a long-term outcome measure. Through this measure, CDC will track improvement in the timeliness of data provided to the nation's health decision makers. The measure will address Health Statistics data in the aggregate; the unit of measurement is months.

<b>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.</b>
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Measure	FY	Target	Result
1. Monitor the nation's health through high-quality data systems.		a) Conduct on-going surveys	N/A
	2006	Conduct four ongoing surveys and data systems that produce detailed trend data for monitoring health	4 (Met)
	2005	Same as above	4 (Met)
	2004	Same as above	4 (Met)
	2003	Same as above	4 (Met)
		b) Increase participant response rates	N/A

**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.**

<b>Measure</b>	<b>FY</b>	<b>Target</b>	<b>Result</b>
	2006	Increase and maintain 78% participation for NHANES through improved outreach with communities, constituents, states and policy makers	78% (Met)
	2005	Same as above	78% (Met)
	2004	Same as above	75% (Unmet)
	2003	Same as above	75% (Unmet)
	2002	Baseline	78%
		c) Work with partners	N/A
	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	Met
	2005	Same as above	Met
	2004	Same as above	Met
	2003	Same as above	Completed work on models, standards, and specifications needed to develop re-engineered vital statistics systems (Met)
2. Percentage of key data users and policy makers, including reimbursable collaborators, that are satisfied with data quality and relevance. [O]	2008	TBD	TBD
	2007	Establish baseline upon completion of survey(s)	3/2007
3. The number of new or revised charts and tables and methodological changes in <i>Health, United States</i> , as a proxy for continuous improvement and innovation in the scope and detail of information.	2008	15	12/2008
	2007	15	12/2007
	2006	15	5 new detailed trend tables and 19 new charts (Met)
	2005	N/A	36
	2004	N/A	21
	2003	Baseline	10
4. Number of improved user tools and technologies and web visits as a proxy for the use of NCHS data.	2008	5/7.528M	12/2008
	2007	5/7.417M	12/2007
	2006	5/6.450M	5/6.7M (Met)
	2005	N/A	5/5.608M
	2004	N/A	7/3.775M

GOAL 1: MONITOR TRENDS IN THE NATION'S HEALTH THROUGH HIGH QUALITY DATA SYSTEMS AND DELIVER TIMELY DATA TO THE NATION'S HEALTH DECISION MAKERS.			
Measure	FY	Target	Result
	2003	N/A	6/3.745M
	2002	Baseline	7/3.448M
<b>Data Source:</b> <u>Measure 1</u> - NHANES, NHIS, National Hospital Discharge Survey (NHDS), and NVSS. <u>Measure 2</u> – Health Statistics' Board of Scientific Counselors and other independent groups. <u>Measure 3</u> - <i>Health, United States</i> . <u>Measure 4</u> - CDC/NCHS Website.			
<b>Data Validation:</b> <u>Measure 1</u> - <u>NHANES</u> : Passive quality control uses automated computer procedures for detecting data anomalies. Active quality control relies on examiner feedback to identify and evaluate problems and select remedies. <u>NHIS</u> : Data are reviewed and analyzed extensively to ensure their validity and reliability. <u>NHDS</u> : Ongoing quality control activities ensure the accuracy of the survey data. <u>NVSS</u> : New birth and death certificates have been designed through a collaborative effort with states, researchers, and other interested parties to enhance the accuracy of birth and death information (implemented in 2003). <u>Measure 2</u> - Targets are under development. NCHS plans to implement a systematic approach and tool for assessing the satisfaction of key data users and policy makers. <u>Measure 3</u> - Improvement and innovation in <i>Health, United States</i> can be assessed through four components: a) new charts in the Chartbook; b) new trend tables; c) tables substantially revised; and d) major methodological changes. The published archived volumes can be inspected yearly and compared to their predecessors to measure the continuous improvement and innovation. <u>Measure 4</u> – Internal checks of data.			
<b>Cross Reference:</b> <u>Measure 1</u> - HHS-5, 500-3; <u>Measure 2</u> – HHS-5, PART, 500-3; <u>Measure 3</u> – HHS-5, PART, 500-3; <u>Measure 4</u> – HHS-5, PART, 500-3			

#### **Goal 1, Performance Measure 1:**

- a) Conduct ongoing surveys.

In FY 2006, all four targeted data systems were operating and producing detailed trend data for monitoring health. For example, one system, NHANES, identified 6,400 individuals, interviewed 5,100 and examined 5,000 individuals in 15 scientifically-selected communities across the nation to generate national estimates. The National Nursing Home Survey, a component of the National Health Care Survey conducted in 2004, surveyed long term care providers for the first time since 1999. The public-use data files were released in August 2006.

- b) Increase participant response rates.

In FY 2006, NHANES achieved a 78 percent response rate through outreach with communities, constituents, states, and policy makers. CDC expects NHANES 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 2006, CDC continued to work with the National Association for Public Health Statistics and Information Systems, individual states, and other agencies including the Social Security Administration 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. Now that the data for FY 2006 have been reported, the measure is retired and will not be reflected in future performance detail.

#### **Goal 1, Performance Measures 2 – 4:**

These new measures have been developed through the PART process for the 2005 cycle and will replace the previous GPRA measure when it is retired.

#### **Goal 1, Performance Measure 2:**

This measure addresses the performance element of quality and scope. CDC will implement a systematic approach and tool for assessing the satisfaction of key data users and policy makers (e.g., reimbursable collaborators, Assistant Secretary for Planning and Evaluation, OMB, Congressional Research Service and others) relative to data quality and scope. The Health Statistics Board of Scientific Counselors is being used to help identify the list of key data users and policy makers to be surveyed, along with those organizations that directly work with CDC through interagency agreements. Performance results will be used by CDC managers to drive program improvements.

**Goal 1, Performance Measure 3:**

This measure addresses the performance element of scope. *Health, United States*, the most comprehensive publication produced by CDC, draws information from each data system, as well as data from other federal partners and collaborators. Improvements in the scope and detail of *Health, United States* are a proxy for the scope of data produced and made available by CDC. Improvement and innovation in *Health, United States* can be assessed through four components: 1) new charts in the Chartbook; 2) new trend tables; 3) tables substantially revised; and 4) major methodological changes. The published archived volumes can be inspected yearly and compared to their predecessors to measure the continuous improvement and innovation.

**Goal 1, Performance Measure 4:**

A primary objective of CDC is to maximize the use of data collected through investment of public funds. As the use of data increases, so does the return on investment. One way to increase use is to make data available in more easily accessible forms. CDC makes its data available in a variety of forms through the Internet and works to improve the speed and efficiency with which people access the data by: a) development of data input statements/programs that allow people quick access to our data files; b) development of masked variance files that allow researchers to more quickly access data; c) development of Fast Stats and Quick Stats to quickly access data files; and d) use of Beyond 20/20 software making it more likely that systems like the CDC Data Warehouse on Trends in Health and Aging, Asthma, Healthy People 2010, and *Healthy Women: State Trends in Health and Mortality*, will be found and used, thereby increasing the use of data already collected.

During 2006, the following improvements have been made on the CDC website:

- NHANES Online Tutorial provides all pertinent information researchers and policy makers need to know about analyzing current NHANES data on a web-based product. The tutorial is designed to help users navigate through the dataset and browse through different modules to gain insight into NHANES data.
- VitalStats site contains a collection of vital statistics products including pre-built tables as well as the ability for users to create tables, charts, grafts and maps based on over 100 variables. The reports allow users access to vital statistics and population data interactively.
- NCHS Survey Measures Catalog: Child and Adolescent Mental Health, provides users with an overview of the measures of child and adolescent mental health and use of mental health services in various surveys of NCHS data systems.
- The Email Subscription service provides a quick, easy way for users to request notification of changes to web pages.
- Provisional Release of NHIS is an accelerated web-based release of NHIS survey data which provides researchers and policy makers quicker access to survey data.

## HEALTH MARKETING

Efficiency Measure	FY	Target	Result
1. Provide "just-in-time" scientific information and education via multiple communication channels to thousands of health professionals, thereby reducing the cost and time of distributing the latest science based information. [E]	2008	5% increase from previous year in number of subscribers and participants of CDC's professional communications projects	12/2008
	2007	5% increase from previous year in number of participants registered in distance learning activities	12/2007
	2006	5% increase from previous year in number of participants registered in distance learning activities.	99,409 (7% increase) (Exceeded)
	2005	5% increase in number of participants registered in distance learning activities.	92,790 (9% increase) (Exceeded)
	2003	Baseline	84,112 participants registered in distance learning activities
<b>Data Source:</b> Participant and subscriber data from the following CDC products: Morbidity and Mortality Weekly Report, Epi-X, Health Alert Network (HAN), Clinician Registry and the Public Health Training Network.			
<b>Data Validation:</b> Data figures are validated through the Division of Health Information Dissemination.			
<b>Cross Reference:</b> HHS-2, 5, HP-23			

### **Efficiency Measure 1:**

The most important tool for frontline practitioners is current, "just-in-time" information and knowledge. Public health and healthcare information must be continuously updated, translated, and communicated to meet changing conditions and threats. Further, information must be available in the form most useful and accessible to health professionals. To meet these needs, CDC is maintaining systems for information and knowledge transfer, and ensuring that scientific and medical information is translated and communicated effectively and that the best practices of public health professionals are shared nationwide. Due to the creation of the National Center for Health Marketing in 2004, this measure has been revised to reflect that multiple communication channels are aligned beyond distance learning alone.

<b>GOAL 1: CDC WILL MAINTAIN AND IMPROVE ITS WEBSITE AND ELECTRONIC COMMUNICATIONS TO PROVIDE SCIENCE BASED HEALTH INFORMATION TO HEALTH CARE PROFESSIONALS, CDC PARTNERS AND THE AMERICAN PUBLIC.</b>			
Measure	FY	Target	Result
1. Increase access and utilization of CDC.gov by public, partners, and other health care professionals.	2008	Baseline +5%	12/2008
	2007	Establish Baseline	12/2007
<b>Data Source:</b> Web usage statistics, web user performance statistics and user satisfaction statistics.			
<b>Data Validation:</b> Staff collect web usage statistics on an on-going basis and monitor improvements over time. User performance and user satisfaction will be measured in user testing and other user research methods (on-line surveys, interviews, etc)			
<b>Cross Reference:</b> HHS-8, -4			

### **Goal 1, Performance Measure 1:**

CDC's web site, <http://www.cdc.gov>, is the primary information source for CDC's various audiences. To ensure rapid dissemination of CDC's scientific information and to ensure broad adoption and application of that scientific research into practice, CDC's scientific information must be distributed in formats (i.e., audio, video), versions (i.e., health professionals/patient) and languages used by its constituents. In addition, CDC's website must increasingly promote its content to various audiences to expedite awareness and usage of the most current scientific information available.

**GOAL 2: INCREASE THE NUMBER OF FRONTLINE PUBLIC HEALTH WORKERS AT THE STATE AND LOCAL LEVEL THAT ARE COMPETENT AND PREPARED TO RESPOND TO BIOTERRORISM, INFECTIOUS DISEASE OUTBREAKS, AND OTHER PUBLIC HEALTH THREATS AND EMERGENCIES; AND PREPARE FRONTLINE STATE AND LOCAL HEALTH DEPARTMENTS AND LABORATORIES TO RESPOND TO CURRENT AND EMERGING PUBLIC HEALTH THREATS.**

Measure	FY	Target	Result
1. Expand frontline public health practitioners' access to Internet-based, CDC-approved public health practice guidelines, scientific/disease reference images, health and medical data, and information on the effectiveness of public health interventions.	2006	a) Expand PHIL links to "just in time" programs by 15. b) Expand PHIL by 1,000 images over FY 2005 result	a) 65 programs (Met) b) 8,400 (Met)
	2005	a) Expand PHIL links to "just in time" programs to 50 (Baseline: 35, 05/2004) b) Expand PHIL by 3,000 images over baseline c) Design customizable functionality for the Local Health website.	a) 50 (Met) b) 7,300 images (Exceeded) c) Unmet
	2004	Expand PHIL by 3,000 images.	6,150 (Unmet)
	2003	Baseline	4,000 images
2. Increase the usage of CDC's online public health emergency alert systems, training materials, and other electronic resources/tools designed to provide information, educational materials, and real-time alerts as measured by the number of subscribers to Epi-X, HAN and national public health radio networks.	2008	<b>Increase by 15% above baseline</b>	12/2008
	2007	Increase by 5% above baseline	12/2007
	2006	Establish Baseline	3/2007
<b>Data Source:</b> Measure 1: Catalog of imagery on PHIL is maintained internally within the Division of Creative Services (DCS). Real time updates on numbers and downloads of imagery are captured on web interface and reported through web servers maintained by DCS personnel. <b>Measure 2:</b> Subscriptions to Epi-X, HAN and partner participation in the National Public Radio Network and other electronic communications systems are monitored and maintained within NCHM. Downloads and other usage information is captured to assess progress.			
<b>Data Validation:</b> <b>Measure 1:</b> PHIL staff, including team of medical illustrators, review imagery for quality before posting and review data being reported on a weekly or as needed basis. <b>Measure 2:</b> NCHM staff use a variety of automated and manual tracking systems to monitor usage of the various communications systems. Data are reviewed by analysts for accuracy and to determine trends in usage and gaps in services.			
<b>Cross Reference:</b> HHS-4, HP-23, *E-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 digital images representing significant public health visual information. Each image includes text meta-tags describing the images that allow for searches by users who are seeking specific images for educational purposes. Clinicians, scientists, researchers, publicists, teachers, students, and the public can access PHIL and obtain images depicting everything from microorganisms to mosquitoes, rashes to risk factors. High resolution formats of the images online allow users to download and use images directly in print or electronic materials. In FY 2004, 6,150 images were digitized, referenced and archived in PHIL. The target of expanding PHIL by 3,000 images for FY 2004 was unmet. The target was not met due to an error in recording the original measure in 2004. In FY 2004, the program developed and measured a GPRA target for PHIL, estimating that the number of PHIL images would total 5,500 by the end of 2004 and 6,500 by the end of FY 2005. These measures were met and exceeded. At the end of FY 2005, the PHIL currently stands at 7,300 images. The target of designing customizable functionality for the Local Health website for FY 2005 was unmet. The PHIL has been modified to include specific audience oriented portals and interface for local public health professionals. Now that the data for FY 2006 have been reported, the measure is retired and will not be reflected in future performance detail.

**Goal 2, Performance Measure 2:**

Improving the usage of CDC's online public health emergency alert systems, training materials, and other electronic resources/tools will have immediate and lasting impact on our ability to protect citizens from natural hazards and terrorist threats. For example, CDC's Epi-X emergency alert system for public health officials nationwide could be expanded to alert other key sectors including government officials, medical officers for businesses, and health care leaders about health emergencies. CDC's online learning tools to train first responders and public health officials involved in preparing for and responding to national emergencies improves our ability to protect the U. S. This will be particularly critical in preparing for a pandemic that may isolate individuals from social gatherings, work, medical facilities, etc. CDC will establish a FY 2006 baseline by March 2007.

<b>GOAL 3: CDC WILL MAINTAIN AND IMPROVE ITS MULTI MEDIA BROADCAST CAPABILITIES (E.G. SATELLITE TELEVISION, WEBCASTS, PODCASTS, VIDEO) TO PROVIDE SCIENCE BASED HEALTH INFORMATION TO HEALTH CARE PROFESSIONALS, CDC PARTNERS AND THE AMERICAN PUBLIC.</b>
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Measure	FY	Target	Result
1. Increase the number of multi-media broadcast outputs to partners and health professionals.	2008	Baseline +5%	12/2008
	2007	Establish Baseline	12/2007
<b>Data Source:</b> The Division of Creative Services will maintain a database of multimedia broadcasts produced and delivered by the division.			
<b>Data Validation:</b> The Performance Management Team will review and pull reports as needed.			
<b>Cross Reference:</b> HHS-5, 8			

**Goal 3, Performance Measure 1:**

The scientific information produced by CDC is only as effective as its translation for and delivery to the many health care, partner and public audiences with which the agency interacts. Satellite distance learning broadcasts for health care professionals have been produced by CDC for many years. In addition, television can be used more broadly with broadcasts to reach the public as well as partners. With the proliferation of new technologies that allow delivery of information to very specific audiences, CDC can now access and use a broad array of multi-media channels to quickly translate science into usable information accessible in many formats (e.g., public cable television, web casts, voice pod casts, etc).

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## ENVIRONMENTAL HEALTH AND INJURY PREVENTION

### ENVIRONMENTAL HEALTH

CDC's Environmental Health program modified some of its measures as a result of OMB feedback during the 2005 PART review process. These changes are noted in the tables and narratives below.

EFFICIENCY GOAL: PROMOTE EFFECTIVE AND EFFICIENT NCEH MANAGEMENT.			
Efficiency Measure	FY	Target	Result
1. By 2006, achieve a 20% cost savings and reduce the number of committee members from 28 to 16 as a result of the consolidation of the Advisory Committee to the Director, NCEH, and the Board of Scientific Counselors (BSC), ATSDR. [E]	2006	20%/16 members	35%/16 members (Exceeded)
	2005	10%/21 members	35%/19 members (Exceeded)
	2003	Baseline	\$225,765 and 28 members
2. Number of FTE's providing program support through the Office of the Director per \$1 million in total program budget. [E]	2008	<b>0.64</b>	10/2008
	2007	0.65	10/2007
	2006	0.66	0.55 (Exceeded)
	2005	N/A	0.67
	2003	Baseline	0.86
<b>Data Source:</b> <u>Measure 1</u> - ATSDR's Office of Science maintains the financial records associated with the Board of Scientific Counselors (BSC) member costs. <u>Measure 2</u> – NCEH/ATSDR Project Profile Database.			
<b>Data Validation:</b> <u>Measure 1</u> - The BSC member cost report is reviewed by Committee Management and is provided to GSA annually. <u>Measure 2</u> - Project Profile maps NCEH/ATSDR goals/measures and FTE's to budget.			
<b>Cross Reference:</b> <u>Measure 1</u> - HHS-8, HP-8.12, -1, 3; <u>Measure 2</u> – HHS-8, PART			

#### **Efficiency Measure 1:**

Environmental Health's Advisory Committee merged with ATSDR's BSC in December 2004. This consolidation decreased the total number of board members and has resulted in a cost savings for FY 2005 and FY 2006. Now that the data for FY 2006 have been reported, the measure is retired and will be replaced with the new efficiency measure developed through PART listed above.

#### **Efficiency Measure 2:**

Environmental Health has taken a number of steps to become more efficient and productive, including reducing the size of the Office of the Director (OD) by decreasing the number of the office's program-support FTEs per million dollars. Further steps are being taken throughout the organization, including the following:

- CDC has achieved efficiencies in measuring environmental chemicals or their metabolites in human samples by developing new analytical biomonitoring methods and improving existing ones, making them faster, more accurate, easier to perform, and less costly.
- CDC has reduced costs and improved efficiency by making the vast majority of its materials available on the Internet. In addition to reducing printing and postal costs, electronic distribution greatly reduces the time required to deliver important information.

GOAL 1: DETERMINE HUMAN HEALTH EFFECTS ASSOCIATED WITH ENVIRONMENTAL EXPOSURES.			
Measure	FY	Target	Result
1. Number of environmental chemicals, including nutritional indicators, that are assessed for exposure of the U.S. population.	2008	<b>280</b>	12/2008
	2007	250	12/2007
	2006	180*	274 (Exceeded)
	2005	165	230 (Exceeded)
	2004	150	150 (Met)
2. Complete assessments examining the possible association between a health effect and an environmental exposure and/or hazard.	2006	17	30 (Exceeded)
	2005	13	21 (Exceeded)
	2004	0	3 (Exceeded)
3. Complete studies to determine the harmful health effects from environmental hazards. <sup>1</sup>	2008	<b>12</b>	12/2008
	2007	25	12/2007
	2006	25	34 (Exceeded)
	2005	6	44 (Exceeded)
	2004	2	27 (Exceeded)
4. Number of laboratory quality standards maintained in certified or participating laboratories for tests such as lipids; newborn screening; those predictive of type 1 diabetes; blood lead, cadmium, and mercury; and nutritional factors.	2008	<b>967</b>	12/2008
	2007	1001	12/2007
	2006	990	987 (Unmet)
	2005	982	904 (Unmet)
	2004	Baseline	866
<b>Data Source:</b> Environmental Health Laboratory – data systems. *Although CDC's <i>National Report on Human Exposure to Environmental Chemicals</i> is issued in odd-numbered years (from the <i>National Center for Health Statistics</i> ), the laboratory analyzes additional chemicals only in even-numbered years.			
<b>Data Validation:</b> Data systems at CDC's Environmental Health Laboratory monitor laboratory performance under Clinical Laboratory Improvement Amendments (CLIA). CDC also conducts quality assurance activities internally to confirm results and ensure their validity.			
<b>Cross Reference:</b> <u>Measure 1</u> - HHS-1, 2, HP-8.24, 8.25, PART, 500-3; <u>Measure 2</u> - HHS-4, 5, HP-8.28, 500-3; <u>Measure 3</u> - HHS-4, HP-8.26, 500-3; <u>Measure 4</u> - PART, 500-3			

<sup>1</sup> The target for FY 2007 was adjusted to reflect the effect of the FY 2007 Continuing Resolution for planning purposes.

#### 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 FY 2006, the laboratory measured levels of some 274 chemicals in people who participated in NHANES and through multiple studies that the lab participates in across the nation and throughout the world. CDC will publicly release exposure data on these chemicals in July 2007 by publishing CDC's *Fourth National Report on Human Exposure to Environmental Chemicals*. Although this document is currently published every two years, the complex analyses reported in the document are conducted year-round. FY 2007 and 2008 targets have been increased in light of scientific advancements which enabled increased assessment capabilities.

#### Goal 1, Performance Measure 2:

The National Environmental Public Health Tracking Program funded 21 states and three local health departments (33 grants) for capacity building, and data and infrastructure enhancement activities. Of these, 12 states and one local health department (17 grants) were funded specifically to conduct data-linkage demonstration projects. In FY 2006, the program supported completion of 30 environmental public health tracking assessments examining the possible association between a health effect and an environmental exposure and/or hazard. Tracking led to 17 public health actions. For example, the Massachusetts Tracking Program found a statistically significant association between the presence of moisture problems in a school and pediatric asthma prevalence, indicating a need for public health

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follow-up or intervention, and provided information for policy changes aimed at reducing mold and moisture in schools. The Tracking Program is working with school officials to identify how to remediate the moisture problems. Such efforts are helping to lay the groundwork for a National Environmental Public Health Tracking Network.

Now that the data for FY 2006 have been reported, the measure is retired and will not be reflected in future performance detail.

**Goal 1, Performance Measure 3:**

Thirty-four studies were completed in FY 2006, which focused on the health effects of air pollutants such as carbon monoxide, water contaminants such as algal toxins, chemicals, and radiation. These studies focused on the health effects of air pollutants such as carbon monoxide, water contaminants such as algal toxins, chemicals, and radiation. Many of these studies were responses to specific state requests, a number of which were related to extreme weather emergencies. Targets were reduced for FY 2008 in light of proposed funding levels for all NCEH programs that contributed to this measure.

**Goal 1, Performance Measure 4:**

This new measure, developed through the 2005 PART process, will ensure the quality of several different tests in a large number of laboratories that participate voluntarily in these quality assurance and standardization programs. Although CDC makes every effort to encourage participation in these programs, it cannot compel laboratories to participate. The target for FY 2006 was not met because the standardization programs are entirely voluntary, and the number of labs that participate fluctuates due to multiple factors, including CDC laboratory requirements and import restrictions.

GOAL 2: PREVENT OR REDUCE ILLNESSES, INJURY, AND DEATH RELATED TO ENVIRONMENTAL RISK FACTORS.			
Measure	FY	Target	Result
1. Percentage reduction in asthma hospitalizations in states funded for partial and full implementation per 100,000 people. [O]	2008	Part A Enhanced: 8% Part B: 15%	12/2011
	2007	Part A Enhanced: 7% Part B: 14%	12/2010
	2006	Part A Enhanced: 6% Part B: 12%	12/2009
	2005	Part A Enhanced: 5% Part B: 10%	12/2008
	2002	Baseline Part A Enhanced	119
	2000	Baseline Part B	147
2. Number of children under age 6 with elevated blood lead levels. [O]	2008	<b>62,350</b>	6/2011
	2007	87,125	6/2010
	2006	111,900	6/2009
	2005	136,675	6/2008
	2004	N/A	240,000
	2003	Baseline	186,200
3. Prevent the spread of disease and treat malnutrition among refugees in complex humanitarian emergencies where CDC provides assistance. [O]	2006	90%	94% (Exceeded)
	2005	100%	100% (Met)
	2004	100%	100% (Met)
4. Percentage increase in the capacity of state health departments to anticipate and prevent the spread of illness/disease outbreaks from food- and water-borne illness.	2008	<b>90%</b>	12/2008
	2007	50%	12/2007
	2006	35%	90% (Exceeded)
	2005	25%	86% (Exceeded)
	2004	Baseline	16%

**GOAL 2: PREVENT OR REDUCE ILLNESSES, INJURY, AND DEATH RELATED TO ENVIRONMENTAL RISK FACTORS.**

**Data Source:** Measure 1 - grantee reporting; Measure 2 – NHANES; Measures 3 and 4 – Data systems are being developed.

**Data Validation:** Measure 1 – CDC project officers will verify that states are fulfilling the requirements of cooperative agreements through routine monitoring of the grants process. Measure 2 - Increased reporting from laboratories electronically, resulting in fewer errors introduced in data during data entry. Measures 3 and 4 – Data validation systems are being developed.

**Cross Reference:** Measure 1 - HHS-1, HP-24.2, PART; Measure 2 - HHS-1, HP-8.11, PART; Measure 3 - HHS-2, HP-8.29, 8.30; Measure 4 - HHS-2, HP-8.27, 8.29, PART

**Goal 2, Performance Measure 1:**

CDC aims to reduce hospitalizations due to asthma by helping state coalitions create and implement comprehensive asthma-control plans that include science-based interventions, partnerships, and asthma tracking systems. The asthma surveillance data is used to identify and provide interventions to people most in need, thereby preventing hospitalizations and other adverse health effects of asthma. This effort is being measured by direct target goals set by Healthy People 2010 and is driven by HHS's strategic goal to "reduce the major threats to the health and well-being of all Americans."

CDC funded 34 state/city/territory grantees in FY 2006 to develop or implement comprehensive asthma control plans. Part B grantees (Michigan, New York, Oregon, California, Illinois, and Minnesota) are funded to implement their asthma control plans fully. This measure is based on the HP 2010 goal of reducing hospitalizations for asthma (goal 24.2). Part A-enhanced (partial implementation) and B states represent 59 percent of the U.S. population.

The reporting dates for this measure have been revised to more correctly reflect the data lag. Issues regarding the quantity, quality, and non-standardized collection of asthma data in states will affect the program's ability to report on this measure. As of December 2006, CDC obtained partial data for 2003. For five of the six Part B states, the age-adjusted hospitalization rate for 2003 is 148. The baseline for Part B states is 146.95; therefore, the partial results for 2003 are not significantly different enough from the actual to make any determination about whether hospitalizations are trending up, down, or level. CDC would like to retire or modify this measure in FY 2009 and replace it with another that is more timely, measurable, and reflective of the program's focus and resources.

**Goal 2, Performance Measure 2:**

CDC's *Third National Report on Human Exposure to Environmental Chemicals* quantified the effectiveness of national, state and local efforts to reduce blood lead levels (BLLs) in young children (aged one to five years). The percentage of young children with elevated BLLs—10 micrograms per deciliter ( $\mu\text{g}/\text{dl}$ ) or higher—has decreased from an estimated 4.4 percent in NHANES III (1991–1994) to 1.2 percent for 2003–2004. This decline indicates that lead exposure among young children in the general population is diminishing.

The 2004 NHANES estimates that approximately 240,000 children (1.2 percent) aged one to six years had elevated BLLs, indicating approximately a 50 percent decline in the percentage of children with elevated BLLs. This figure should be interpreted cautiously, however, because the NHANES estimates are based on small numbers of children with  $\text{BLLs} \geq 10\mu\text{g}/\text{dl}$ , and there is limited experience comparing estimates intervals containing only two years of data instead of the four years preferred by CDC's National Center for Health Statistics.

**Goal 2, Performance Measure 3:**

The International Emergency and Refugee Health (IERH) program coordinates CDC's response to complex humanitarian emergencies, such as technical assistance to other federal agencies, the United Nations (U.N.), and organizations in areas related to the health of refugee populations. CDC provides interventions to ensure disease outbreaks are prevented from spreading among refugees and displaced persons in complex humanitarian emergencies. For example, CDC provided technical assistance and statistical support for the analysis of data from the joint nutrition and food security assessment in Darfur; conducted a nutrition and micronutrient survey and assessed U.S.-supported primary health care programs in Burmese refugee camps in Thailand; assisted UNICEF in the design and implementation of a measles immunization campaign in south Sudan, whereby an estimated 500,000 children were vaccinated; and supported U.S. government response efforts following the earthquake in Pakistan. The target for FY 2006 was decreased to 90 percent (from the FY 2005 target of 100 percent), due to limitations on staff and other resources. In some cases, providing assistance may also be against U.S. foreign policy or be otherwise inappropriate. Now that the data for FY 2006 have been reported, the measure is retired and will not be reflected in future performance detail.

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**Goal 2, Performance Measure 4:**

This measure tracks the increased capability of states to prevent and respond to outbreaks from food, water, and air contaminants/vectors. CDC currently works with 427 state and local environmental health service (EHS) delivery programs to increase their capacity to prevent the spread of outbreaks from food- and water-borne illness. Examples include the following:

- Provided technical assistance, funds, and training to nine states in EHS-NET activities to collect, analyze, and disseminate information on the factors most likely to contribute to food- and water- borne illness and outbreaks;
- Provided technical assistance to 15 states on drinking water and recreational water supplies; and
- Funded nine state and local health departments to build or enhance environmental health services capacity built on the Ten Essential Public Health Services framework.

GOAL 3: BUILD AND ENHANCE EFFECTIVE PARTNERSHIPS TO IMPROVE ENVIRONMENTAL HEALTH CAPACITY.			
Measure	FY	Target	Result
1. Provide assistance to partners.	2006	20	20 (Met)
	2005	20	20 (Met)
	2004	20	20 (Met)

**Data Source:** Internal Strategic Planning Documents.

**Data Validation:** Data are maintained and verified by Policy Leads in the three Environmental Health Divisions.

**Cross Reference:** HHS-4, 5, HP-8.20, 8.21, 500-3

**Goal 3, Performance Measure 1:**

CDC continues to develop active partnerships with a variety of partners, including state health departments, academic institutions, non-governmental organizations, and other local, state, and federal health and environmental agencies. Examples include the National Healthy Homes Training Center and Network, Eastern Kentucky University, The World Health Organization, the United Nations High Commissioner on Refugees, the World Food Program, the National Environmental Health Association, the Association of Public Health Laboratories, the Immune Deficiency Foundation, Columbia University, the University of California at Berkeley, the Mount Sinai School of Medicine, the Environmental Protection Agency, the National Aeronautics and Space Administration, the United States Geological Survey, the University of Miami, the National Institutes of Health, and the National Oceanic and Atmospheric Administration.. Now that the data for FY 2006 have been reported, the measure is retired and will not be reflected in future performance detail.

## **INJURY PREVENTION AND CONTROL**

The National Center for Injury Prevention and Control (NCIPC) underwent the Program Rating Assessment Tool (PART) process in FY 2006 for the FY 2008 budget submission. As a result of new PART goals and measures, several of the performance budget measures have been changed or retired, and new measures have been added.

Efficiency Measure	FY	Target	Result
1. Through the implementation of web-based systems for state and territorial agencies, decrease the time between the submission of an application and the receipt of funds for injury prevention and control efforts. [E]	2006	Maintain FY 2005 Target	81 days average (Unmet)
	2005	5% faster	117 days average (Unmet)
	2004	Establish baseline	67 days (average)(Met)
2. Reduce the amount of time to submit funding packages for non-research funding opportunities to CDC's Procurement and Grants Office. [E]	2008	<b>14 days</b>	9/2008
	2007	26 days	9/2007
	2006	Establish baseline	52 days (Met)
<b>Data Source:</b> <u>Measure 1</u> - Office of Program Management and Operations. <u>Measure 2</u> - Office of Program Management and Operations.			
<b>Data Validation:</b> <u>Measure 1</u> - Verification with CDC's NCIPC Extramural Tracking System (NEXT) data system. <u>Measure 2</u> - Verification with NEXT data system.			
<b>Cross Reference:</b> <u>Measure 1</u> - HHS-8, <sup>1</sup> -3, 4. <u>Measure 2</u> - HHS-8, PART			

### **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 grantee information to be retrieved faster and more accurately than what can be collected otherwise. In addition to the time saved, this measure also improves customer service. As more applications become standardized and grantees become more familiar with their format, the grant application process will require less time and provide for more efficient means of tracking and monitoring the status of submissions. Now that the data for FY 2006 have been reported, the measure is retired and will not be reflected in future performance detail.

In FY 2005, NCIPC began the implementation process to track the new PGO baseline measures established in FY 2004. In FY 2006, the number of days decreased by 36 from FY 2005. NCIPC continues to make improvements to streamlining the process through establishing timelines and working with program personnel.

### **Efficiency Measure 2:**

This efficiency measure will track the Injury Center's efforts to meet one of CDC's overarching Key Performance Indicators. The funding package cycle time is defined as the time from the conclusion of the review panel until the funding package is sent to CDC's Procurement and Grants Office (PGO). During this time frame, NCIPC is required to summarize the reviews (primary and secondary) of each application for a particular funding opportunity and develop a funding package document to submit to PGO. PGO's target for this time frame is seven days. In FY 2006, NCIPC took an average of 52 days to submit the funding package to PGO. NCIPC will use its NEXT system to verify its performance for this measure.

CDC's Injury Prevention program was reviewed by the Office of Management and Budget for the FY 2006 PART process. This process helped CDC redirect and refine its performance measures for injury prevention and control. Based on its PART review, CDC has revised its goals for injury prevention. CDC will track the following goals and measures (Goals 4 and 5) and will no longer report on Goals 1 through 3, after reporting for their FY 2006 targets is complete.

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<b>GOAL 1: INCREASE THE CAPACITY OF INJURY PREVENTION AND CONTROL PROGRAMS TO ADDRESS THE PREVENTION OF INJURIES AND VIOLENCE.</b>			
<b>Measure</b>	<b>FY</b>	<b>Target</b>	<b>Result</b>
1. Reduce the incidence of rape or attempted rape by increasing the number of school and college-aged people reached through educational programs.	2006	3% increase from previous year	12/2007
	2005	3% increase from previous year	3,195,563 (Unmet)
	2004	Establish baseline	3,328,735 (Met)
2. Among the states receiving funding from CDC, reduce deaths from residential fire. [O]	2006	1.27 per 100,000	2/2009
	2005	1.28 per 100,000	2/2008
	2004	1.29 per 100,000	2/2007
	2003	1.30 per 100,000	1.17 per 100,000 (Exceeded)
	2001	Baseline	1.26 per 100,000

**Data Source:** Measure 1 – Grantee Annual Reports; Measure 2 - National Vital Statistics System.

**Data Validation:** Measure 1 – Data are checked through on-going communication with grantees and through site visits.  
Measure 2 – Data verified through CDC's National Center for Injury Prevention and Control, Office of Statistics and Programming Analysis.

**Cross Reference:** Measure 1 - HHS-1, HP-15.35, 500-5; Measure 2 - HHS-1, HP-15.25, 500-5

**Goal 1, Performance Measure 1:**

CDC is developing a measure to track its performance in the rape prevention and education program. A baseline of 3,328,735 school and college-aged people reached through programs supported by the Rape Prevention and Education Program has been established by collecting data from grantees through the Rape Prevention and Education Grants System. The language of this measure was modified to clarify its meaning. This measure will be retired after data have been reported for FY 2006.

The number of students reached in FY 2005 was 3,195,563; therefore, the target of a three percent increase for FY 2005 was not met. FY 2005 was the first year NCIPC implemented the process to track increases in the number of school and college-aged people through educational programs, and targets were based on best estimates of achievable results. NCIPC will continue to strive to streamline its efforts to develop strategies that are effective in educating the target population.

**Goal 1, Performance Measure 2:**

Residential fire deaths, among states receiving funding for residential fire prevention activities, were 1.17 per 100,000 people, which exceeds the target for FY 2003. Now that the data for FY 2006 have been reported, the measure is retired and will not be reflected in future performance detail.

<b>GOAL 2: MONITOR AND DETECT FATAL AND NON FATAL INJURIES.</b>			
<b>Measure</b>	<b>FY</b>	<b>Target</b>	<b>Result</b>
1. Increase the number of states receiving CDC funding to monitor, identify, and track injuries.		a) TBI Surveillance	a) TBI Surveillance
	2006	Maintain FY 2005 state funding levels	30 states funded (Met)
	2005	Maintain FY 2004 state funding levels	Met
	2004	Disseminate TBI data at state level	Met
	2003	Revise Central Nervous System (CNS) surveillance guidelines to include protocols for collecting data on mild TBI	Met
		b) NEISS All Injury Surveillance	b)NEISS All Injury Surveillance
	2006	Maintain FY 2005 activities	2005 statistics were made available to the public in September 2006

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GOAL 2: MONITOR AND DETECT FATAL AND NON FATAL INJURIES.			
Measure	FY	Target	Result
	2005	Provide national statistics via an Internet-based electronic reporting system made available to the public	Met
	2004	Publish national statistics on non-fatal injuries treated in emergency departments by leading causes of injury	Met
	2003	Implement an NEISS All Injury Program special study on traumatic brain injury	Met
		c) NVDRS Surveillance	c) NVDRS Surveillance
	2006	Maintain FY 2005 state funding levels to continue implementing NVDRS	17 states funded (Met)
	2005	Maintain FY 2004 state funding levels to continue implementing NVDRS	17 states funded (Met)
	2004	Maintain FY 2003 state funding levels to continue implementing NVDRS	17 states funded (Exceeded)
	2003	Increase the number of states implementing NVDRS from 6 to 8	13 states funded (Exceeded)
<b>Data Source:</b> a) Division of Injury and Disability, Outcomes & Programs; b) Office of Statistics and Programming; c) Division of Violence Prevention			
<b>Data Validation:</b> Verification with NCIPC Extramural Tracking System (NEXT) data system			
<b>Cross Reference:</b> HHS-5, HP-15.1, 15.10, 500-5			

**Goal 2, Performance Measure 1:**

a) Traumatic Brain Injury (TBI) Surveillance – CDC's Public Health Injury Surveillance and Prevention Program funds 30 state health departments to conduct injury surveillance, including reporting the number of people who die or are hospitalized with a TBI.

b) National Electronic Injury Surveillance System (NEISS) – NEISS, funded by CDC in collaboration with the U.S. Consumer Product Safety Commission (CPSC), provides injury data from inner city, urban, suburban, and rural children's hospitals. CDC uses NEISS data to generate national estimates of nonfatal injuries in the U.S. and to guide decisions and policies about injury prevention and control. National statistics on nonfatal injuries treated in emergency departments can be accessed via the internet at <http://www.cdc.gov/ncipc/wisqars/default.htm>, meeting the target that was established for FY 2005.

c) National Violent Death Reporting System (NVDRS) – In FY 2005, CDC funded 17 states to implement NVDRS, gathering and sharing state-level data about violent deaths. This state-based system collects data from medical examiners, coroners, police, crime labs, and death certificates to understand the circumstances surrounding violent deaths. This information can be used to develop, inform, and evaluate violence prevention programs. CDC met the target established for both FY 2005 and FY 2006.

Now that the data for FY 2006 have been reported, the measure is retired and will not be reflected in future performance detail.

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**GOAL 3: CONDUCT A TARGETED PROGRAM OF RESEARCH TO REDUCE INJURY RELATED DEATH AND DISABILITY.**

Measure	FY	Target	Result
1. Develop new or improved approaches to prevent and control death and disability due to injuries.	2006	Maintain FY 2005 funding level for research agenda targeted areas; peer review 98% of research projects	Maintained funding for targeted areas, 98% of research projects peer reviewed (Met)
	2005	Maintain FY 2004 funding level for research agenda targeted areas; peer review 98% of research projects	Maintained funding for targeted areas, 98% of research projects peer reviewed (Met)
	2004	Maintain FY 2003 funding level for research agenda targeted areas; increase peer-review by 5%	Maintained funding for targeted areas, 93% of research awards peer-reviewed (Exceeded)
	2003	Fund one research project for injury research in targeted areas; increase peer-review by 5%	90% of research awards peer-reviewed (Exceeded)
	2002	Baseline	66% of research awards peer-reviewed; 134 projects funded

**Data Source:** Office of Extramural Research.

**Data Validation:** Verification with NCIPC Extramural Tracking System (NEXT) data system.

**Cross Reference:** HHS-4, HP-15, 500-3

**Goal 3, Performance Measure 1:**

CDC research focuses on reducing morbidity, disability, death, and lowering costs associated with injuries. CDC's extramural research program supports the following:

- Research centers for broad-based injury control.
- Centers for youth violence prevention.
- Individual, investigator-initiated research that is targeted to specific studies.
- Grants for small business innovative research.

CDC also conducts evaluation research to ascertain the efficacy and effectiveness of interventions and other factors that put people at risk for injury. The extramural program supports a productive and relevant research portfolio and uses a peer review approach that is based on review by the Injury Research Grant Review Committee (IRGRC). IRGRC is composed of experts in injury-related scientific disciplines or current research areas that enable them to evaluate the scientific and technical merits of grant applications. CDC achieved this measure in FY 2006. Now that the data for FY 2006 have been reported, the measure is retired and will not be reflected in future performance detail.

PERFORMANCE DETAIL  
ENVIRONMENTAL HEALTH AND INJURY PREVENTION  
INJURY PREVENTION AND CONTROL

Following the 2006 PART review, Injury will continue to measure Goals 4 and 5 as reported below.

GOAL 4: ACHIEVE REDUCTIONS IN THE BURDEN OF INJURIES, DISABILITY, OR DEATH FROM INTENTIONAL INJURIES FOR PEOPLE AT ALL LIFE STAGES.			
Measure	FY	Target	Result
1. Reduce youth homicide rate by 0.1 per 100,000 annually. [O]	2008	8.8/100,000	2/2010
	2005	8.9/100,000	2/2007
	2004	N/A	8.9/100,000
	2003	Baseline	9.4/100,000
2. Reduce victimization of youth enrolled in grades 9-12 as measured by a reduction in the lifetime prevalence of unwanted sexual intercourse, the 12-month incidence of dating violence, and the 12-month incidence of physical fighting. [O]	2009	A) 6.7% B) 8.1% C) 29.3%	12/2010
	2007	A) 6.9% B) 8.4% C) 30.3%	12/2008
	2005	A) 7.2% B) 8.8% C) 31.3%	A) 7.5% B) 9.2% (Unmet) C) 35.9% (Unmet)
	2003	N/A	A) 9.0% B) 8.9% C) 33.0%
	2001	Baseline	A) 7.7% B) 9.5% C) 33.2%
<b>Data Source:</b> <u>Measure 1</u> – National Violent Death Reporting System (NVDRS), <u>Measure 2</u> - Youth Risk Behavior Survey			
<b>Data Validation:</b> <u>Measure 1</u> – Data verified through CDC's National Center for Injury Prevention and Control, Office of Statistics and Programming Analysis. <u>Measure 2</u> – Data verified through CDC's National Center for Injury Prevention and Control, Office of Statistics and Programming Analysis.			
<b>Cross Reference:</b> <u>Measure 1</u> - HHS-1, HP-15.32, PART. <u>Measure 2</u> - HHS-1, HP-15.34, HP-15.35, HP-15.38, PART			

#### Goal 4, Performance Measure 1:

This measure is monitored utilizing data from persons aged 15-24 years among states participating in the National Violent Death Reporting System in 2003. This measure contributes to CDC's long term PART goal to reduce homicide rates among youth aged 15-24 by 10 percent in NVDRS states with FY 2003 baseline data.

Youth homicide is the second leading cause of death for youth ages 15-24 years in the United States. and the fourth leading cause of death for children ages 1-14 years.

#### Goal 4, Performance Measure 2:

This measure contributes to CDC's long-term PART goal to impact self-reported victimization of youth as measured by reductions in two of three of the following: unwanted sexual intercourse, dating violence, and physical fighting.

NCIPC funds numerous programs and activities to address the victimization of youth. This annual performance measure consists of three aspects of victimization of youth – unwanted sexual intercourse, dating violence, and physical fighting. The data source of youth victimization is CDC's Youth Risk Behavior Survey (YRBS). In the YRBS, students enrolled in grades nine to twelve are asked these questions:

- During the past 12 months, did your boyfriend or girlfriend ever hit, slap, or physically hurt you on purpose?
- Have you ever been physically forced to have sexual intercourse when you did not want to?
- During the past 12 months, how many times were you in a physical fight?

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This measure was not met for FY 2005, the first year of implementation of a process to track trends for the measure. Targeted reductions were the result of best estimates based on trends derived from data available during the PART review. NCIPC continues to streamline efforts to achieve its targets in reducing incidences of unwanted sexual intercourse, dating violence, and physical fighting.

<b>GOAL 5: ACHIEVE REDUCTIONS IN THE BURDEN OF INJURIES, DISABILITY OR DEATH FROM UNINTENTIONAL INJURIES FOR PEOPLE AT ALL LIFE STAGES.</b>			
<b>Measure</b>	<b>FY</b>	<b>Target</b>	<b>Result</b>
1. Among the states receiving funding from CDC, reduce deaths from residential fires by 0.01 per 100,000 population. [O]	2008	<b>1.12/100,000</b>	10/2010
	2007	1.13/100,000	10/2009
	2003	N/A	1.17/100,000
	2002	N/A	1.15/100,000
	2001	Baseline	1.26/100,000
2. Achieve an age-adjusted fall fatality rate among persons age 65+ of no more than 69.6 per 100,000. [O]	2008	<b>47.8/100,000</b>	10/2010
	2007	45.6/100,000	10/2009
	2006	43.4/100,000	10/2008
	2005	41.2/100,000	10/2007
	2004	39.0/100,000	39.2/100,000 (Unmet)
	2001	Baseline	32.5/100,000
3. Decrease the estimated percent increase of age-adjusted fall fatality rates among persons age 65+ years. [O]	2008	<b>9.30% reduction</b>	10/2010
	2007	9.10% reduction	10/2009
	2006	8.82% reduction	10/2008
	2005	8.39% reduction	10/2007
	2004	7.67% reduction	5.52% (Unmet)
	2001	Baseline	32.5/100,000
<b>Data Source:</b> <a href="#">Measure 1</a> – National Vital Statistics System; <a href="#">Measure 2</a> - National Vital Statistics System; <a href="#">Measure 3</a> - National Vital Statistics System			
<b>Data Validation:</b> <a href="#">Measures 1-3</a> – Data verified through CDC's National Center for Injury Prevention and Control, Office of Statistics and Programming Analysis.			
<b>Cross Reference:</b> <a href="#">Measure 1</a> – HHS-1, HP-15.25, 500-5, PART; <a href="#">Measure 2</a> - HHS-1, HP-15.14, PART ; <a href="#">Measure 3</a> - HHS-1, HP-15.14, PART			

#### **Goal 5, Performance Measure 1:**

This measure contributes to CDC's long term PART goal to reduce deaths from residential fires to 1.02 per 100,000 population among the states receiving funding from CDC. This measure reflects more ambitious targets as it includes a greater number of states, compared to the existing GPRA measure which is being retired after data are reported for FY 2006.

In 2004, fire departments responded to more than 410,000 home fires in the United States which claimed the lives of an estimated 3,190 people (not including fire fighters) and injured another 14,175. Almost half of home fire deaths occurred in homes without working smoke detectors. Residential fires accounted for approximately 80 percent of all fire-related injuries and deaths in 2004. Persons at greatest risk of sustaining fire-related injuries are children ages five years and younger and adults ages 65 and older, African Americans, Native Americans, and Alaska Natives, rural dwellers, and persons living in substandard housing or older manufactured homes.

#### **Goal 5, Performance Measure 2:**

More than one third of adults ages 65 years and older fall each year. Of those who fall, 20 percent to 30 percent suffer moderate to severe injuries such as hip fractures or head traumas that reduce mobility and independence, and increase the risk of premature death. Falls result in more than 1.8 million adults 65 years and older treated in emergency departments for fall-related injuries, over 421,000 hospitalizations, and approximately 13,000 deaths

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annually. Among older adults, falls are the leading cause of injury deaths. In 2000, the direct medical cost totaled \$179 million dollars for fatal falls.

In FY 2004, NCIPC began the implementation process to track the new older adult falls baseline measures. The target of 39.0 per 100,000 population was based on a best estimation of an achievable result, given trends and existing prevention efforts. The actual result of 39.2 percent did come near the target of 39.0 percent or less. NCIPC continues to streamline efforts to achieve its targets through research and dissemination of effective older adult fall prevention measures.

**Goal 5, Performance Measure 3:**

In 2001, the age-adjusted annual fall fatality rate among persons aged 65 years and older was 32.5 per 100,000 population. Based on a review of national data since 1981, NCIPC anticipates that fall fatality rates in this population will continue to rise over the next decade due to continuing decreases in mortality from cardiovascular and other chronic diseases, as well as increases in general life expectancy. In addition, the targeted population for this measure is will increase greatly as baby boomers age and enter the age range in large numbers. CDC estimates that the percent increase of fall fatality rates for this population without CDC activity will be 73.8 per 100,000 in 2018. With CDC's activities in this area, NCIPC has targeted an incidence rate of 69.6 per 100,000 in 2018, or a 10 percent decrease in the estimated percent increase of age-adjusted fall fatality rates.

FY 2004 was the first year NCIPC implemented the process to track reductions in increases of falls among older adults. NCIPC will continue to strive to streamline its efforts to develop strategies that are effective in getting interventions into the community in order to meet future goals.

## OCCUPATIONAL SAFETY AND HEALTH

Efficiency Measure	FY	Target	Result
1. Percent of grant award/funding decisions made available to applicants within nine months of application receipt or deadline date, while maintaining a credible and efficient, two-level peer review system. [E]	2008	72%	12/2008
	2007	69%	12/2007
	2006	66%	68% (Exceeded)
	2005	Baseline	60%
2. Determine future human capital resources needed to support programmatic strategic goals, focusing on workforce development/training and succession planning. [E]  A) Improve CDC NIOSH's supervisor to employee ratio by a specific % over previous year results. B) Increase the number of employees with current mission-oriented Individual Development Plans (IDPs) to a specified % of the CDC NIOSH civil service population. C) Develop succession plans for percentage of key leadership positions with anticipated retirement eligible dates for specified FYs.	2006	A) 2.5% over FY 2005 results. B) 65% C) 100% for FY 2008 to FY 2009.	A) Ratio 1:12.1 (Exceeded) B) 83% (Exceeded) C) 100% (Met)
	2005	A) 5% over FY 2004 results. B) 60% C) 100% for FY 2007 to FY 2008.	A) Ratio 1:11.6 (Exceeded) B) 70% (Exceeded) C) 100% (Met)
	2004	Establish Baseline	A) Ratio 1:10.98 B) IDPs 18.6% C) Succession plans 0% (All Met)
<b>Data Source:</b> <u>Measure 1</u> - IMPAC II, the NIH grant review and administration information system, and NIOSH Office of Extramural Program tracking tools. <u>Measure 2</u> - a) CDC Workforce Information Zone (WIZ), Atlanta Human Resource Center (AHRC); b) Direct report from Divisions to the NIOSH Office of the Deputy Director; c) WIZ, AHRC and formal employee queries by NIOSH Office of the Deputy Director.			
<b>Data Validation:</b> <u>Measure 1</u> - Staff members performing award notification utilize delivery and read receipt notifications. Data is reviewed three times each year by program staff, concurrent with each review council round. <u>Measure 2</u> - a) WIZ is an agency-wide program used to collect and report on human resource actions processed by the AHRC. The Office of the Deputy Director reviews pertinent data in the system monthly to assess progress in improving supervisor to employee ratio; b) Quarterly, the Office of the Deputy Director requests each Division to complete a standardized spreadsheet with basic personnel information and information on active, mission-oriented IDPs; c) Annually, the Office of the Deputy Director reviews the retirement eligibility date of NIOSH employees. Employees with eligibility dates that are current, or within the next five years, and hold a key leadership position are queried as to their retirement plans. If retirement is anticipated in the next five years, the NIOSH Lead Team establishes a succession plan to support the transition and ensure stability within the Institute.			
<b>Cross Reference:</b> <u>Measure 1</u> – HHS-8, PART; <u>Measure 2</u> - HHS-8, *=1			

### Efficiency Measure 1:

CDC partners with the National Institutes of Health (NIH) Center for Scientific Review to process grant applications. In keeping with the effort to coordinate resources across HHS, CDC utilizes NIH's peer review and management system and computer program (IMPAC II) for receipt and referral of grant applications. By doing so, CDC streamlines services for the extramural community, ensures uniformity of responses to applicants, and achieves cost efficiencies for the Institute. The two-pronged approach to peer review is highly praised in the scientific community and is considered the "gold standard" for quality peer review. IMPAC II is a real-time system that can be monitored at any stage of the approval process. This review system is based on an eight to nine month timeline. This measure was developed through the 2004 PART process.

### Efficiency Measure 2:

Through this measure, CDC will strive to meet the human capital goals of the President's Management Agenda, which calls for a reduction in layers of government, a reduction in the number of managers in each agency, and the ability to provide employee development and succession planning to enhance the work environment and provide future leadership. Progress is already being made towards each of these goals. Now that the data for FY 2006 have been reported, the measure is retired and will not be reflected in future performance detail.

*RESEARCH*

<b>GOAL 1: CONDUCT RESEARCH TO REDUCE WORK RELATED ILLNESSES AND INJURIES.</b>			
<b>Measure</b>	<b>FY</b>	<b>Target</b>	<b>Result</b>
1. Progress in targeting new research to the areas of occupational safety and health (OSH) most relevant to future improvements in workplace protection.	2008	Evaluate relevance of fourth 1/5 of CDC NIOSH program activities according to specifications below.	12/2009
	2007	Evaluate relevance of third 1/5 of CDC NIOSH program activities according to specifications below.	12/2008
	2006	Evaluate relevance of second 1/5 of CDC NIOSH program activities according to specifications below.	12/2007
2. Increase the relevance of occupational safety and health research for future improvements in workplace protection.	2005	Evaluate relevance of first 1/5 of CDC NIOSH program activities with 80% rating 4 or 5 (on a scale of 1 to 5, with 5 being the highest) as judged by independent panels of external customers, stakeholders, and experts.	2/2007
	2004	Finalize arrangements with National Academies (NA) for relevance review.	Met
	2003	Conduct baseline evaluation among safety and health professionals of CDC NIOSH research relevance for practical workplace results.	Met
3. Ensure the quality of occupational safety and health research, as measured by peer review.  A) Specified % of internal research programs and % of research grants and cooperative agreements result in peer-reviewed publications within one year of project completion.  B) Specified % of new internal research projects and % of new research grants and cooperative agreements are reviewed by external peer-review at project inception.	2006	A) 90% and 100% B) 80% and 100%	A) 90% and 100% (Met) B) 98% and 100% (Exceeded and Met)
	2005	A) 80% and 90% B) 70% and 100%	A) 89% and 90% (Exceeded and Met) B) 93% and 100% (Exceeded)
	2004	A) 70% and 80% B) 60% and 90%	A) 63% and 82% (Unmet and Exceeded) B) 86% and 100% (Exceeded)
	2003	A) 60% and 70% B) 40% and 90%	A) 62% and data not available (Exceeded) B) 60% and 100% (Exceeded)
4. Improve the quality and usefulness of tracking information for safety and health professionals and researchers in targeting research and intervention priorities; and measure the success of implemented intervention strategies.	2008	<b>Same target as for FY 2004</b>	A & B: 12/2008 C: 6/2009
	2007	Same target as for FY 2004	A & B: 12/2007 C: 6/2008

**GOAL 1: CONDUCT RESEARCH TO REDUCE WORK RELATED ILLNESSES AND INJURIES.**

<b>Measure</b>	<b>FY</b>	<b>Target</b>	<b>Result</b>
	2006	Same target as for FY 2004	A) 155 research and intervention projects were based on tracking information (Met); B) 15 intervention programs used tracking information to demonstrate the success of the intervention strategy (Met); C: 6/2007
	2005	Same target as for FY 2004	A) 150 research and intervention projects were based on tracking information; B) 11 intervention programs used tracking information to demonstrate the success of the intervention strategy; C) 8.0 adults per 100,000 with elevated blood lead levels (All Met)
2004		A) Evaluate the role that tracking information had in designing research and intervention projects. B) Identify the role that follow-up tracking information can have in assessing the success of interventions. C) Heightened use of tracking data as a way to reduce the prevalence rate of elevated blood lead concentrations in persons due to work exposures by 3%.	A) 153 research and intervention projects were based on tracking information; B) 21 intervention programs used tracking information to demonstrate the success of the intervention strategy; C) 3% reduction in the prevalence rate of elevated blood lead levels in adults, 16 and older (9.3 adults per 100,000) (All Met)
2003		A) Establish a baseline by identifying those research and intervention projects that were based upon tracking information. B) Identify CDC NIOSH intervention programs that have used tracking information to demonstrate success of the intervention strategy. C) Heightened use of tracking data as a way to reduce the prevalence rate of elevated blood lead concentrations in persons due to work exposures by establishing a baseline of the number of persons per 100,000 employed with elevated blood lead levels of 25 µg/dL or greater.	A) 187 (Baseline) B) 21 (Baseline) C) 12.0 (Baseline) (All Met)

<b>GOAL 1: CONDUCT RESEARCH TO REDUCE WORK RELATED ILLNESSES AND INJURIES.</b>			
<b>Measure</b>	<b>FY</b>	<b>Target</b>	<b>Result</b>
5. Percentage of NIOSH programs that will have completed program-specific outcome measures and targets in conjunction with stakeholders and customers.	2008	70%	9/2008
	2007	60%	9/2007
	2006	50%	52% (Exceeded)
	2005	33%	36% (Exceeded)
<b>Data Source:</b> Measures 1, 2, and 5 - National Academies (NA) direct report to NIOSH. <b>Measure 3</b> - NIOSHTIC II database and NIOSH Project Planning and Management (NPPM) system. <b>Measure 4</b> – a and b) NPPM system; c) National prevalence derived from the state-based Adult Blood Lead Epidemiology and Surveillance (ABLES) programs.			
<b>Data Validation:</b> Measures 1, 2, and 5 - NIOSH has contracted with the NA to complete reviews of at least two NIOSH sector programs annually. Upon completion of the reviews, the NA submits a formal report to NIOSH, which includes a quantitative rating of the program, summary of findings, refined outcome measures and suggestions for future improvement. <b>Measure 3</b> - a) Annually, the Office of the Director develops a report on the number of publications produced by select projects using the NIOSHTIC II database and NPPM system. This report is sent to the Divisions for review, to ensure the accuracy and completion of the information; b) Internal Projects – Projects competing for new NORA funds undergo a formal external peer-review process. The NPPM system is used to identify new projects and peer review is verified by the NIOSH Associate Director for Science. External Projects - All external projects are reviewed through the NIH peer review system. The date and details of the reviews are recorded and reviewed by the NIOSH Office of Extramural Programs. <b>Measure 4</b> – a and b) Program analysts in each division as well as the Office of the Director review project plans in the NPPM system to assess the use of tracking information in the development and/or completion of projects; c) NIOSH statisticians check ABLES data quarterly. Annually, the data is compiled and reviewed by the data manager using MS Access for validity of dates, ages, repeated tests on the same individual, and for completeness of data on exposure sources. Independently, a NIOSH project officer uses SAS to compare annual frequency distributions with previous years' data to check for unusual patterns, potential misclassification of exposure sources, and other data problems. The data manager and project officer then reconcile any differences in their annual analyses.			
<b>Cross Reference:</b> <u>Measure 1</u> - HHS-4, HP-20, *-5, 500-3, PART, <u>Measure 2</u> - HHS-4, HP-20, *-5, 500-3, <u>Measure 3</u> - HHS-4, HP-20, *-5, 500-3, <u>Measure 4</u> - HHS-4, HP-20.7, *-5, 500-3, <u>Measure 5</u> - HHS-4, PART			

#### **Goal 1, Performance Measure 1:**

CDC has entered into a contract with the National Academies (NA) to conduct a comprehensive review of its occupational safety and health research program portfolio. In FY 2005, the NA Framework Committee established comprehensive evaluation criteria and assembled evaluation panels for the first phase of the review – mining and hearing loss prevention. The development of quantitative evaluation criteria was an extensive process, and took longer than expected. Once completed, the NA evaluation panels employed the criteria to conduct the first phase of the review. To provide the NA panels with ample time to conduct the review, the reporting deadline was extended. NA panels have reported on the hearing loss program and will provide a final report and rating on the mining program in early 2007. The respiratory disease and agriculture programs are also currently under 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. The NA panels will provide a final report and rating on the mining program in February 2007. Once the report is received, CDC will report the data and this measure will be retired.

#### **Goal 1, Performance Measure 3:**

CDC disseminates its research findings through a variety of publications. In FY 2006, 90 percent of internal research projects and 100 percent of CDC funded research grants and cooperative agreements for occupational safety and health resulted in peer-reviewed publications, meeting the target. Peer-reviewed publications are valuable resources, especially in the dissemination of research findings to occupational safety and health professionals. Alternative publications are also used, such as CDC numbered documents and CDC Alerts, to direct research findings to a broader audience, including employees and employers. This further promotes the translation of research findings into effective prevention practices adopted in the workplace.

In FY 2006, 98 percent of new internal research projects and 100 percent of new research grants and cooperative agreements were externally peer-reviewed at project inception. All new CDC research grants and cooperative agreements are peer-reviewed through the NIH system. CDC exceeded this portion of the FY 2006 target. Now that the data for FY 2006 have been reported, the measure is retired and will not be reflected in future performance detail.

**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 2006, 155 research and intervention projects were based on tracking information, and 15 intervention programs used tracking information to demonstrate the effectiveness of the programs' strategies. 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 13 states participating in the CDC's States Occupational Surveillance Consortium (SOSC). In 2005, data from the pilot study was published, providing a broad view of occupational safety and health at the state level and differences that exist among states. Currently, all states funded by CDC for occupational health surveillance track these indicators.

**Goal 1, Performance Measure 5:**

As part of the National Academies (NA) comprehensive review of research activities referenced in performance measure one above, all programs will develop comprehensive outcome-based measures and targets in conjunction with stakeholders and customers. In FY 2006, 52 percent of CDC's programs – mining, construction, agriculture and health care – completed outcome measures and targets. These measures and targets formed the framework for evaluation of the impact of research by NA, and will establish transparent customer-based targets across the entire portfolio.

*INTERVENTIONS, RECOMMENDATIONS AND CAPACITY BUILDING*

GOAL 2: PROMOTE SAFE AND HEALTHY WORKPLACES THROUGH INTERVENTIONS, RECOMMENDATIONS AND CAPACITY BUILDING.			
Measure	FY	Target	Result
1. Increase the quality, relevancy, and usefulness of CDC information and recommendations to occupational safety and health professionals, workers, employers, government, the scientific community, and the public.	2006	Same target as for FY 2005	12/2007
	2005	Increase the number of occupational safety and health professionals who use CDC as a source for occupational safety and health information; continue to establish baseline.	Unmet <sup>1</sup> Revised survey instrument
	2004	Increase the use of CDC information and recommendations by occupational safety and health professionals, workers, employers, government, the scientific community, and the public.	79% (Met)
	2003	Establish baseline on the percentage of occupational safety and health professionals who use occupational safety and health information published within the last 12 months by CDC.	74% (Met)
2. Increase the percentage of CDC NIOSH-trained professionals who enter the field of occupational safety and health after graduation.	2008	<b>80%</b>	12/2008
	2007	80%	12/2007
	2006	80%	80% (Met)
	2005	75%	80%
	2004	70%	75%
	2003	Establish baseline	68% (Met)

<b>GOAL 2: PROMOTE SAFE AND HEALTHY WORKPLACES THROUGH INTERVENTIONS, RECOMMENDATIONS AND CAPACITY BUILDING.</b>			
<b>Measure</b>	<b>FY</b>	<b>Target</b>	<b>Result</b>
3. Reduce the annual incidence of work injuries, illnesses, and fatalities, in targeted sectors. [O] A) Reduction of non-fatal injuries among youth ages 15–17. B) Reduction of fatal injuries among youth 15–17. C) Reduction in the annual number of silicosis deaths among U.S. residents age 15 and older.	2008	A) 15% B) 30% C) 5%	A) 12/2008 B) 12/2008 C) 12/2008
	2007	A) 15% B) 30% C) 5%	A) 12/2007 B) 12/2007 C) 12/2007
	2006	A) 7% B) 9% C) 5%	A) 15% (Exceeded) B) 3/2007 C) 0% (Unmet)
	2005	A) 5% B) 7% C) 5%	A) 21% (Exceeded) B) 23% (Exceeded) C) 18% (Exceeded)
	2004	A) 3% B) 5% C) 5%	A) 9.6% (Exceeded); B) 35.7% (Exceeded); C) 9.0% (Exceeded)
	2003	Establish baselines	A) 5.2 (Met) B) 3.5 (Met) C) 180 (Met)
4. Increase workplace use of control and personal protective technologies in targeted sectors. [O] A) Increase the availability of CBRN-certified respirators for use during a CBRN event to a specified % of the professional firefighters. B) Increase the percentage of U.S. pavers with installed engineering controls to a specified %.	2006	B) 90%	B) 6/2007
	2005	A) 15% B) 80%	A) 46% (Exceeded) B) 80% (Met)
	2004	A) 10% B) 70%	A) 13% (Exceeded) B) 70% (Met)
	2003	A) 3% B) Establish baselines	A) 3% (Met) B) 60% (Met)
5. Reduce occupational illness and injury as measured by: A) Percent reductions in respirable coal dust overexposure. B) Percent reduction in fatalities and injuries in roadway construction. C) Percent of firefighters and first responders' access to chemical, biological, radiological, and nuclear respirators. [O]	2014	A) 50% reduction B) 40% reduction C) 75% reduction	A) 12/2014 B) 12/2014 C) 12/2014
	2003	Baseline	A) >15% B) 154% C) >7%

**GOAL 2: PROMOTE SAFE AND HEALTHY WORKPLACES THROUGH INTERVENTIONS, RECOMMENDATIONS AND CAPACITY BUILDING.**

Measure	FY	Target	Result
6. Percentage of: A) Companies employing those with NIOSH training that rank the value added to the organization as good or excellent. B) Professionals with academic or continuing education training. [O]	2009	A) 80% B) Increase of 15%	A) 12/2009 B) 12/2009
	2003	Baselines	A) 68% B) 1,405 full-time academic trainees; 31,508 continuing education trainees

**Data Source:** Measures 1 and 6 - NIOSH Customer Satisfaction Survey. Measure 2 - NIOSH Office of Extramural Programs training grantee annual progress reports, which include performance data. Measure 3 - a) National Electronic Injury Surveillance System (NEISS); b) Census of Fatal Occupational Injuries (CFOI) special research file provided to NIOSH by Bureau of Labor Statistics; c) National Occupational Respiratory Mortality System (NORMS), an interactive query system designed to generate statistics, charts, and maps relating to mortality from occupationally-related lung diseases. Measure 4 - a) NIOSH survey of professional firefighters, and the International Safety Equipment Association (ISEA); b) NIOSH and National Asphalt Pavement Association (NAPA) collaboration. Measure 5 - a) The Mine Safety and Health Administration (MSHA) and NIOSH data sets that are shared between the agencies - MSHA data is routinely collected as part of the enforcement and compliance requirements, and NIOSH data collected during field investigations, in support of current and future research experiments.; b) See Measure 3b; c) See Measure 4a.

**Data Validation:** Measures 1 and 6 - The survey is conducted by the NIOSH Education and Information Division, in compliance with the standards of the Data Quality Act. Measure 2 - OEP staff review and verify data with grantees via phone or email contact, as needed. Measure 3 - a) The Consumer Product Safety Commission (CPSC) annually visits emergency departments that submit data to NEISS to assess case capture, and review records as they are submitted for completeness and internal consistency. NIOSH receives NEISS data quarterly and reviews the subset of work-related cases that CPSC provides to ensure the cases meet NIOSH definitions of work-relatedness. NIOSH reviews a sample of cases after coding by a contractor to ensure a high level of accuracy for codes that describe source of injury and event/exposure leading to injury; b) NIOSH receives the special CFOI file annually. To avoid duplication of fatalities in the counts, source documents are matched using the decedent's name and other information. To ensure an accurate count of fatal occupational injuries, the census program requires that for each case, the work relationship (that is, whether a fatality is work related) be substantiated by two or more independent source documents or a source document and a follow-up questionnaire; c) NORMS is based on public-use, multiple cause of death data files obtained annually from the National Center for Health Statistics (NCHS). NCHS performs data quality check to remove invalid codes, verify the coding of certain rare causes of death, and ensure age/cause and sex/cause compatibility. To ensure the accuracy of the NORMS results, NIOSH compares the findings to the NCHS control tables. Measure 4 - a) NIOSH conducted a telephone survey of a representative sample of professional firefighters and analyzes proprietary data provided by ISEA for each manufacturer of NIOSH-approved CBRN respiratory protective devices to assess distribution in the field. NIOSH has also incorporated questions regarding CBRN SCBA availability in the Fire Fighter Fatality Investigation and Prevention Program Evaluation Fire Department Survey, administered to 3,000 fire departments throughout the country in spring 2005; b) In 1997, the partnership between NIOSH and the National Asphalt Pavement Association (NAPA) resulted in a voluntary agreement that equipment manufacturers would incorporate effective fume emission controls on all new highway class pavers. Reports for NAPA and assessments of the average service life (10 years) for highway class pavers enable NIOSH to assess the use of pavers equipped with the recommended engineering controls. Measure 5 - a) The MSHA data is collected according to the agency's standard rigorous sampling and handling protocols. The validation of NIOSH data is ensured by following the protocols developed during the generation of the research proposals. The proposals are peer-reviewed and include calibration requirements for the measurement and handling of the dust samples, as well as procedures for analyzing the results and ensuring the meaningfulness of the data points; b) See Measure 3b; c) See Measure 4b.

**Cross Reference:** Measure 1 – HHS-4, \*\*-4, 5; Measure 2 - HHS-4, \*\*-5, PART; Measure 3 - HHS-1, HP-20.1, 20.2, 20.4, \*\*-5; Measure 4 - HHS-1, 2 \*\*-5, 500-3; Measure 5 - HHS-1, PART; Measure 6 - HHS-4, \*\*-5, PART

<sup>1</sup> CDC delayed the next customer survey until 2006, to better measure the impact of this and other new communication tools.

**Goal 2, Performance Measure 1:**

CDC engages in capacity building activities through information dissemination. Previously, CDC assessed its capacity building capabilities through information dissemination by conducting a survey questionnaire of four professional associations. In 2005, CDC and the occupational safety and health community began efforts to redesign NORA, aligning OSH research with eight industrial sectors, to improve the impact of OSH research and information. This redesign necessitated the revision of the CDC-NIOSH Customer Satisfaction survey and the establishment of a new baseline. Pending OMB approval, the revised survey will query more than 1,500 members of various trade

associations and labor unions on the use of NIOSH information services, the utility of the information provided, and OSH information needs. The findings will assist CDC in future efforts to partner and communicate with the OSH community. Due to the necessary redesign of the survey, CDC is unable to report results for FY 2005. Once OMB approval is received, CDC will immediately begin conducting the survey. The findings of this survey will be used to establish a baseline by which progress of the new sector-based approach can be tracked.

One example of a CDC communication tool that has been successfully in disseminating information to the broad OSH community is the "NIOSH eNews". This monthly electronic newsletter is designed to provide stakeholders and researchers with a timely update on what's new in worker safety and health. Currently, more than 25,000 readers subscribe to eNews, enabling them to receive each new issue automatically by e-mail. The electronic format is versatile and interactive allowing readers to access other online resources, as well as provide CDC with comments and feedback on our performance.

**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 2006, 461 professionals graduated from these programs with specialized training in disciplines that include occupational medicine, occupational health nursing, industrial hygiene, occupational safety, and other closely related occupational safety and health fields of study.

CDC estimates that about half of all U.S. occupational safety and health professionals graduate from CDC-supported programs at the masters and doctoral levels. In FY 2006, CDC met its performance goal with 80 percent of the professionals graduating from CDC-funded programs pursuing careers in occupational safety and health.

**Goal 2, Performance Measure 3:**

CDC 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 2006, CDC produced previously unavailable data to help guide prevention efforts in the agricultural sector and led a federal interagency working group on childhood agricultural injury prevention. The agriculture sector accounts for more work-related deaths of youth than any other industrial sector. CDC also provided input into the revised child labor regulations that became effective February 14, 2005. Building upon curricula and teaching tools developed by CDC-funded grants and others, CDC is developing a core occupational safety and health curriculum for young workers that engages students and teachers in the exploration of risks to youth in the workplace, their rights and relevant labor laws, common workplace hazards and controls, communication skills, and young workers' role in emergency preparedness and response. In FY 2005, CDC worked with state educational agencies to pilot test this curriculum. CDC is currently revising the curriculum based on this pilot test and will work with partners in FY 2007 to distribute this curriculum to educators. CDC will report on sub-target B of this measure in March 2007, when updated data is published by the Bureau of Labor Statistics.

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. Although the target for FY 2006 was unmet, silicosis deaths have leveled off since the baseline was developed for this measure in FY 2003. In general, silicosis develops slowly, usually appearing 10 to 30 years after exposure. Therefore fluctuations in the annual number of silicosis deaths often do not reflect improvements made over time.

**Goal 2, Performance Measure 4:**

CDC has issued Chemical, Biological, Radiological and Nuclear (CBRN) Air Purifying Respirators (APR) approvals and implemented standards for upgrading traditional firefighter Self Contained Breathing Apparatus (SCBA) to CBRN protection levels. In addition to developing respirator certification standards and user guidelines, CDC is committed to ensuring that CBRN-protective respirators are available to professional firefighters. Based on a CDC/NIOSH telephone survey of professional firefighters and International Safety Equipment Association data, CDC has increased availability of CBRN-approved respirators to professional firefighters to 46 percent - exceeding the FY 2005 – FY 2007 targets. This increase is due to CDC certification of additional commercial respirators, the approval of seven additional CBRN Air Purifying Respirator models and more accurate reporting. Part A of this measure will be

retired, as targets for FY 2005 – FY 2007 have been exceeded; however information on the availability of CBRN respirators will continue to be reported in Goal 2, Performance Measure 5c.

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. This measure will be retired after data are reported for FY 2006.

**Goal 2, Performance Measure 5:**

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 6:**

The impact of training can be evaluated as a product of two metrics: the number of trained professionals in occupational safety and health positions, and the value of these trainees to their organizations. In addition, a third metric is used to judge the success of training programs based on the satisfaction of trainees. New surveys will be conducted to augment existing data on the impact of training programs. Follow-up surveys with trainees will determine their level of satisfaction with their education, and surveys of companies hiring trainees will judge the impact they are having in the workplace. In addition, efforts will continue to track the number of professionals with occupational safety and health duties that have academic or continuing education training.

**GLOBAL HEALTH****GLOBAL AIDS PROGRAM**

In 2005, OMB conducted a PART review of the President's Emergency Plan for AIDS Relief (known as the Emergency Plan, or PEPFAR). The Office of the Global AIDS Coordinator (OGAC), Department of State, coordinated the review, which included activities by OGAC, the CDC Global AIDS Program (CDC/GAP), HRSA, NIH, USAID, Peace Corps, and the Departments of Defense, State, Labor, and Commerce. OMB conducted separate PART reviews of the focus country programs, other bilateral programs, and Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) activities. As a result of this review, beginning in the FY 2007 budget cycle, GAP has included performance measures for focus country programs and other bilateral programs that reflect GAP's efforts for the Emergency Plan.

GAP currently has offices in 29 countries (including the 15 focus countries) as part of coordinated interagency USG teams implementing the Emergency Plan. GAP supports more than 25 additional countries through its headquarters and regional offices. GAP assists with HIV prevention, care and treatment; laboratory capacity building; surveillance, monitoring and evaluation; and public health evaluation research through partnerships with host governments, ministries of health, non-governmental organizations, international organizations, U.S.-based universities, and the private sector to help implement the Emergency Plan, including supporting the Global Fund. GAP is uniquely positioned to coordinate with CDC's other global health programs, such as global disease detection, public health training, and prevention and control of other infectious diseases such as malaria and tuberculosis, as well as with CDC's domestic HIV/AIDS prevention programs in the United States.

As a part of the comprehensive USG Global HIV/AIDS strategy, through the Office of the Global AIDS Coordinator (OGAC), GAP has worked closely with partners including USAID and other government agencies, the World Health Organization, the World Bank, and others to develop a set of common core indicators of progress. A monitoring and evaluation plan for all activities has been developed and all countries report on their core indicators of progress on an annual basis.

**GOAL 1: BY 2010, WORK WITH OTHER COUNTRIES, INTERNATIONAL ORGANIZATIONS, THE U.S. DEPARTMENT OF STATE, USAID, AND OTHER PARTNERS TO ACHIEVE THE UNITED NATIONS GENERAL ASSEMBLY SPECIAL SESSION ON HIV/AIDS GOAL OF REDUCING PREVALENCE AMONG 15 TO 24 YEARS OF AGE.**

Measure	FY	Target	Result
1. Initiate, expand, or strengthen HIV/AIDS prevention, care, treatment, and support activities globally.  (Includes all GAP funding except that specifically dedicated to the PMTCT).		Surveillance	Surveillance
	2006	24 countries <sup>1</sup>	24 (Met)
	2005	25 countries	25 (Met)
	2004	25 countries	25 (Met)
	2003	25 countries	25 (Met)
	2002	25 countries	25 (Met)
		Voluntary counseling and testing	Voluntary counseling and testing
	2006	24 countries <sup>1</sup>	24 (Met)
	2005	25 countries	25 (Met)
	2004	25 countries	25 (Met)
	2003	25 countries	20 (Unmet)
	2002	25 countries	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
	2006	24 countries <sup>1</sup>	24 (Met)
	2005	25 countries	25 (Met)
	2004	25 countries	23 (Unmet)
	2003	25 countries	20 (Unmet)
	2002	25 countries	20 (Unmet)

**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.**

**Data Source:** GAP Planning and Reporting System.

**Data Validation:** Data are provided by each country and are checked for accuracy and inconsistencies by the GAP Monitoring and Evaluation Team.

**Cross Reference:** 500-6

<sup>1</sup> This measure was calculated based on an in-country presence of GAP staff. In 2006, CDC did not have an in-country presence in Senegal, but supported Senegal with technical assistance from HQ through the USAID office in Senegal.

**Goal 1, Performance Measure 1:**

**Surveillance:** In FY 2006, CDC supported surveillance in 24 countries and four regional offices, with a particular interest in the 15 PEPFAR focus countries.

**Voluntary Counseling and Testing:** In FY 2006, CDC strengthened voluntary counseling and testing (C&T) programs by providing technical assistance to ensure the quality and accuracy of HIV testing, strengthening laboratory diagnostic capabilities, identifying methods to target groups at high risk, and enhancing linkages between C&T and health and social services.

**Locally Appropriate Technical Assistance for Treatment of STDs, TB, and Other Opportunistic Infections:** In FY 2006, CDC worked to initiate, expand or strengthen locally appropriate technical assistance for treatment of sexually transmitted infections (STIs), TB, and other AIDS-related diseases.

Now that the data for FY 2005 have been reported, the measure is retired and will not be reflected in future performance detail. It will be replaced with new measures developed for PART.

**PART MEASURES**

In 2005, as a result of the PART review, CDC added two new goals and accompanying performance measures to reflect the coordinated activities of GAP under the Emergency Plan. These goals reflect GAP's work in the focus countries (Goal 2) and in other bilateral programs (Goal 3). As a key implementing agency of the Emergency Plan, GAP works closely with other USG agencies and departments in the 15 focus countries to develop one country plan and annual report with indicators for each focus country. The 13 other bilateral countries received more than \$5 million total in U.S. Government (USG) funds in 2005 and also report on standard indicators that reflect the efforts of all USG agencies. The new performance measures draw from these indicators and provide information on the number of individuals receiving services; targets are adjusted to reflect the latest information available by the OGAC. Measures included below are reflective of CDC's mission and programmatic activities.

**GOAL 2: THE GLOBAL AIDS PROGRAM WILL HELP IMPLEMENT THE PRESIDENT'S EMERGENCY PLAN FOR AIDS RELIEF IN 15 FOCUS COUNTRIES BY PARTNERING WITH OTHER USG AGENCIES TO ACHIEVE THE GOALS OF TREATING 2 MILLION HIV INFECTED PEOPLE AND CARING FOR 10 MILLION PEOPLE INFECTED WITH OR AFFECTED BY HIV/AIDS BY 2008, AND PREVENTING 7 MILLION NEW HIV INFECTIONS BY 2010.**

Focus Country Performance Measures (Includes all USG activities)			
Measure	FY	Target <sup>1</sup>	Result
1. Number of people receiving HIV/AIDS treatment.	2008	1,300,000	3/2009
	2007	860,000	3/2008
	2006	665,000	822,000
	2005	470,000	401,233 (Unmet) <sup>2</sup>
	2004	200,000	235,000
	2003	Baseline	66,911
2. Number of individuals provided with general HIV-related palliative care/basic health care and support during the reporting period, including TB. [O]	2008	Under development	3/2009
	2007	3,130,341	3/2008
	2006	2,496,157	2,464,063 (Unmet) <sup>2</sup>
	2005	1,662,820	1,397,555 (Unmet)
	2004	Baseline	854,800

**GOAL 2: THE GLOBAL AIDS PROGRAM WILL HELP IMPLEMENT THE PRESIDENT'S EMERGENCY PLAN FOR AIDS RELIEF IN 15 FOCUS COUNTRIES BY PARTNERING WITH OTHER USG AGENCIES TO ACHIEVE THE GOALS OF TREATING 2 MILLION HIV INFECTED PEOPLE AND CARING FOR 10 MILLION PEOPLE INFECTED WITH OR AFFECTED BY HIV/AIDS BY 2008, AND PREVENTING 7 MILLION NEW HIV INFECTIONS BY 2010.**

Focus Country Performance Measures (Includes all USG activities)			
Measure	FY	Target <sup>1</sup>	Result
3. Number of pregnant women receiving PMTCT services, including counseling and testing during the reporting period.	2008	Under development	3/2009
	2007	2,916,379	3/2008
	2006	2,100,292	2,837,409 (Met)
	2005	2,372,913	1,957,932 (Unmet)
	2004	Baseline	1,271,300
4. Number of individuals who received counseling and testing during the reporting period (counseling includes the provision of test results to clients).	2008	Under development	3/2009
	2007	7,671,789	3/2008
	2006	5,590,762	6,426,120 (Met)
	2005	3,982,958	4,653,257 (Met)
	2004	Baseline	1,791,900

**Data Source:** Country Operational Plans (COPS) database

**Data Validation:** All USG data are validated by the OGAC Strategic Information team following their internal procedures.

**Cross Reference:** All measures – PART, 500-6

<sup>1</sup>Targets are established for entire USG efforts by the Office of the Global AIDS Coordinator (OGAC). OGAC has not released target numbers for USG measures for focus countries for those marked "Under development."

<sup>2</sup>These targets are set by the US Office of the Global AIDS Coordinator and represent the total USG contribution to achieving this goal. As a result, CDC cannot provide an explanation for not meeting this USG-wide target.

**Goal 2, Performance Measure 1:**

People receiving antiretroviral therapy (ART): Baseline 2003 numbers are an aggregate of totals from different population-based studies conducted from 1998-2002 in the 14 original focus countries.

**Goal 2, Performance Measure 2:**

Palliative care: Palliative care comprises a broad range of services including physical, psychological, spiritual, and social support services. Please note that beginning in 2006, both target and actual number include TB (2004 and 2005 did not include TB in either target or actuals).

**Goal 2, Performance Measure 3:**

PMTCT services: A program level indicator that is standardized across the 15 focus countries. Expansion of PMTCT services and programs has been a priority since the beginning of the Emergency Plan's implementation.

**Goal 2, Performance Measure 4:**

Counseling and Testing: A program level indicator that is standardized across the 15 focus countries.

**GOAL 3: THE GLOBAL AIDS PROGRAM WILL HELP IMPLEMENT THE PRESIDENT'S EMERGENCY PLAN FOR AIDS RELIEF IN THE OTHER BILATERAL COUNTRIES BY PARTNERING WITH OTHER USG AGENCIES, INTERNATIONAL AND HOST COUNTRY ORGANIZATIONS TO ACHIEVE THE GOALS OF PREVENTING NEW HIV INFECTIONS, TREATING HIV INFECTED PEOPLE, AND CARING FOR PEOPLE INFECTED WITH OR AFFECTED BY HIV/AIDS.**

Other Bilateral Countries Performance Measures (Includes all USG activities)			
Measure	FY	Target <sup>1</sup>	Result
1. Number of individuals receiving antiretroviral therapy at the end of the reporting period (includes PMTCT+ sites).	2008	<b>Under development</b>	3/2009
	2007	Under Development	3/2008
	2006	43,859	165,100
	2005	33,958	69,766 <sup>2</sup> (Met)
	2004	Baseline	20,774
2. Number of individuals trained to provide laboratory-related activities.	2008	Under development	3/2009
	2007	Under development	3/2008
	2006	1,770	6,252
	2005	1,772	1,772 (Met)
	2004	Baseline	1,488
3. Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results.	2008	Under development	3/2009
	2007	Under Development	3/2008
	2006	633,185	3/2007
	2005	623,787	603,913 <sup>2</sup> (Unmet)
	2004	Baseline	145,133
4. Number of individuals who received counseling and testing during the reporting period.	2008	Under development	3/2009
	2007	Under Development	3/2008
	2006	1,049,628	2,485,900
	2005	955,492	1,710,048 (Met)
	2004	Baseline	773,649
<b>Data Source:</b> GAP Planning and Reporting System and OGAC.			
<b>Data Validation:</b> All USG data are validated by the OGAC Strategic Information team following their internal procedures.			
<b>Cross Reference:</b> All measures – PART, 500-6			

<sup>1</sup> Targets are established for entire USG efforts by the Office of the Global AIDS Coordinator (OGAC). OGAC has not released targets numbers for USG measures for other bilateral programs in boxes marked "Under development."

<sup>2</sup> This data was generated before the other bilateral countries received any specific guidance on monitoring and evaluation from OGAC. Hence, indicator values for certain programmatic activities appear low or non-existent due to lack of available existing data. Indicators include data from CDC, USAID, Peace Corps, and Department of Defense (DoD) and are based on each agency's existing indicators for reporting which were mapped into PEPFAR indicators. The reported indicators are a subset of the full set of PEPFAR indicators, i.e., only those for which FY 2005 USG data is available.

**Goal 3, Performance Measure 1:**

People receiving antiretroviral therapy (ART): A program level indicator that is standardized for use across all other bilateral countries receiving \$1 million or more in FY 2005 USG HIV/AIDS funding. The data from 2004 and 2005 are from USAID and HHS/CDC and were not under the guidance of PEPFAR reporting (Double counting may exist due to overlap between agency programs). FY 2006 data for the other bilateral countries will not be available until March 2007.

**Goal 3, Performance Measure 2:**

Individuals trained in lab services: A program level indicator that is standardized for use across all other bilateral countries receiving \$1 million or more in USG HIV/AIDS funding in FY 2005. This activity is run by HHS/CDC and thus will be reported on by CDC only. The data from 2004 and 2005 is from CDC and was not under the guidance of PEPFAR reporting. 2006 is the first reporting cycle that PEPFAR guidance is in effect for the countries receiving \$1 million or more in USG HIV/AIDS funding. FY 2006 data for the other bilateral countries will not be available until March 2007.

**Goal 3, Performance Measure 3:**

PMTCT: A program level indicator that is standardized for use across all other bilateral countries receiving \$1 million or more in USG HIV/AIDS funding in FY 2005. Through the Emergency Plan, the USG will continue to support counseling and testing for pregnant women, emphasizing the provision of tests results. The data from 2004 and 2005 are from USAID and HHS/CDC and were not under the guidance of PEPFAR reporting (Double counting may exist due to overlap between agency programs). 2006 is the first reporting cycle that PEPFAR guidance was in effect for the countries receiving \$1 million or more in USG HIV/AIDS funding. FY 2006 data for the other bilateral countries will not be available until March 2007.

**Goal 3, Performance Measure 4:**

Counseling and Testing: A program level indicator that is standardized for use across all other bilateral countries receiving \$1 million or more in USG HIV/AIDS funding in FY 2005. The data from 2004 and 2005 are from USAID and HHS/CDC and were not under the guidance of PEPFAR reporting (Double counting may exist due to overlap between agency programs). 2006 is the first reporting cycle that PEPFAR guidance was in effect for the countries receiving \$1 million or more in USG HIV/AIDS funding. FY 2006 data for the other bilateral countries will not be available until March 2007.

**GLOBAL IMMUNIZATION PROGRAM**

In 2005, the Global Immunization Program underwent OMB's PART review process. New performance measures were developed as a result and are included below in the tables and narrative.

Efficiency Measure	FY	Target	Result
1. The portion of the annual budget that directly supports the program purpose in the field. [E]	2008	>=90%	4/2009
	2007	>=90%	4/2008
	2006	>=90%	4/2007
	2005	>=90%	93% (Met)
	2004	Baseline	93%
<b>Data Source:</b> Data will be tracked and analyzed through IRIS, GMIS, UFMS, and ICE systems.			
<b>Data Validation:</b> The monthly budget update is reviewed for accuracy by the Division's Associate Director for Management and Operations (ADMO). The ADMO monitors appropriate use of funds by category (polio, measles, and global disease detection) and CAN numbers. The ADMO works with the Polio Eradication Branch and the Global Measles Branch to ensure that funds are completely obligated by the end of the fiscal year. The overall budget is reviewed by the Branch Chiefs, Deputy Division Director, and Division Director quarterly.			
<b>Cross Reference:</b> HHS-8, PART			

**Efficiency Measure:**

Developed through the 2005 PART process, this measure demonstrates that most of the Global Immunization Program's funding is used to support mission-critical activities directly through CDC's global partners, the World Health Organization (WHO), the United Nations Children's Fund (UNICEF), the Pan American Health Organization (PAHO) and the United Nations Foundation (UNF). Specifically, these funds are used to purchase measles and polio vaccine and/or to provide technical or operational support through these agencies. To continue to meet global goals, CDC needs to maintain this efficiency and support for these activities.

GOAL 4: HELP DOMESTIC AND INTERNATIONAL PARTNERS ACHIEVE WORLD HEALTH ORGANIZATION'S GOAL OF GLOBAL POLIO ERADICATION.			
Measure	FY	Target	Result
1. Purchase doses of oral polio vaccine for mass immunization campaigns in Asia, Africa, and Europe.	2008	<b>425 million doses</b>	6/2009
	2007	425 million doses	6/2008
	2006	500 million doses	6/2007
	2005	500 million doses	428 million doses (Unmet)
	2004	500 million doses	500 million doses (Met)
	2003	600 million doses	550 million doses (Unmet)
2. Number of countries in the world with endemic wild polio virus. [O]	2008	<b>0 endemic countries</b>	8/2009
	2007	3 endemic countries	8/2008
	2006	4 endemic countries	8/2007
	2005	5 endemic countries	4 endemic countries (Met)
	2004	N/A	6 endemic countries
	2002	Baseline	7 endemic countries
<b>Data Source:</b> Measure 1 - UNICEF provides the number of doses of polio purchased with CDC funding in an annual report that is part of the CDC/UNICEF cooperative agreement. Measure 2 - WHO provides the polio case data generated from reports submitted by countries.			
<b>Data Validation:</b> Case count and surveillance indicators provided weekly by WHO are reviewed and analyzed by the Global Immunization Division.			
<b>Cross Reference:</b> Measure 1 - HHS-1; Measure 2 - HHS-1, PART			

#### Goal 4, Performance Measure 1:

In FY 2005, CDC purchased 428 million doses of Oral Polio Vaccine (OPV). Fewer doses were purchased than targeted for FY 2005. This was primarily due to two factors:

- OPV funding in FY 2005 was reduced slightly from FY 2004 funding levels. This was a result of decreased overall funding from FY 2004 to FY 2005 and the availability of funds from other donors for OPV, allowing CDC to use some funding to fill critical operational gaps.
- The cost of OPV increased by 10 – 20 percent, from \$0.10/dose in FY 2004 to \$0.11/dose in FY 2005 and \$0.12/dose for monovalent OPV (mOPV). mOPV was reintroduced in FY 2005 and not used in FY 2004.

#### Goal 4, Performance Measure 2:

Global polio incidence has declined by more than 99 percent from 1988 to 2005. The number of endemic countries has been reduced from 125 polio-endemic countries in 1988 to four countries in early 2006 (Afghanistan, India, Nigeria and Pakistan). Egypt and Niger were removed from the list of endemic countries in January 2006, although Niger continues to have limited transmission following repeated importations of wild poliovirus from Nigeria. The target for number of endemic countries has been increased to three in FY 2007 because India, Nigeria, and likely Afghanistan will not meet the goal of ending polio transmission in 2006 due to multiple program deficiencies or accessibility issues due to conflict. About 250,000 lives have been saved and four million cases of childhood paralysis have been avoided.

In 2005, the American Region of WHO completed its fourteenth year without a reported case of polio due to the wild virus. The Western Pacific Region (includes China, Vietnam, and Cambodia among its 35 countries) and the European Region (51 countries) have achieved regional eradication of polio. However, large, ongoing polio outbreaks in northern Nigeria and western Uttar Pradesh, India are likely to delay polio eradication until 2007. As long as polio transmission occurs anywhere in the world, it remains a threat to American children. CDC will continue to fight against polio by collaborating with partners to increase the number and quality of National Immunization Days and intensify implementation of the other strategies to interrupt transmission. CDC will continue to provide scientific assistance to improve tracking to certify that polio eradication has occurred.

Measure 2 is an adaptation developed as a result of the 2005 PART process and serves as both a long-term and annual measure. The ultimate objective is to eradicate polio. The previous goal tracked cases of polio, whereas the new goal tracks number of countries with endemic polio.

GOAL 5: WORK WITH GLOBAL PARTNERS TO REDUCE THE CUMULATIVE GLOBAL MEASLES RELATED MORTALITY BY 90% COMPARED WITH 2000 ESTIMATES (BASELINE 777,000 DEATHS) AND TO MAINTAIN ELIMINATION OF ENDEMIC MEASLES TRANSMISSION IN ALL 47 COUNTRIES OF THE AMERICAS.			
Measure	FY	Target	Result
1. Number of global measles-related deaths. [O]	2008	327,600	12/2009
	2007	363,400	12/2008
	2006	399,200	12/2007
	2005	435,000	345,000 (Exceeded)
	2004	500,000	454,000 (Exceeded)
	2000	Baseline	777,000
2. Number of non-import measles cases in all 47 countries of the Americas as a measure of maintaining elimination of endemic measles transmission. [O]	2008	0	7/2009
	2007	0	6/2008
	2006	0	6/2007
	2005	0	0 (Met)
	2004	0	78 (Unmet)
	2000	Baseline	1,755
<b>Data Source:</b> World Health Organization, Pan American Health Organization			
<b>Data Validation:</b> A team of WHO epidemiologists and statisticians annually review the estimates using a standardized methodology. This is supplemented with information obtained in national surveillance and program reviews as well as special studies. In addition, WHO works with partners to examine the quality and accuracy of the data.			
<b>Cross Reference:</b> Measure 1 - HHS-1, PART; Measure 2 - HHS-1, PART			

#### Goal 5, Performance Measure 1:

CDC provided scientific, technical, and programmatic support for measles outbreak investigations in Pakistan, Tanzania, Kenya, Sudan, Georgia and the Ukraine; supported reviews of immunization surveillance in the African and the Western Pacific regions and a national review in the Republic of the Maldives and the Philippines, helped conduct a review of accelerated measles control activities in the western provinces of China, and evaluated the regional surveillance system for measles, rubella and congenital rubella syndrome in the American and European regions. CDC also contributed funding and or technical assistance to measles immunization campaigns in 23 African countries and to those planned and conducted in Afghanistan, Armenia, Bangladesh, Bhutan, Fiji Indonesia, Pakistan, Yemen, and others. These efforts resulted in recommendations for improved surveillance and control activities and contributed substantially to declines in measles mortality.

Measles has been eliminated from the Western Hemisphere. Measles mortality in the African region has been reduced by 74 percent since 1999, and measles mortality worldwide has been reduced by 60 percent. The target for this goal is based on 2000 data estimating 777,000 deaths; by 2010 CDC aims to reduce the global measles-related mortality by 90 percent compared with this estimate from 2000.

The model used to generate the preceding year coverage is based on routine and campaign related performance data that is captured by a joint WHO/UNICEF reporting form. WHO & UNICEF convene a panel committee to review this data annually and come to consensus on estimates of disease burden.

#### Goal 5, Performance Measure 2:

This performance measure corresponds with the goal adopted by the Pan American Health Organization (PAHO). 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 345,000 deaths in 2005 and was the leading cause of death among children under five years of age from a vaccine-preventable disease.

PERFORMANCE DETAIL  
PUBLIC HEALTH IMPROVEMENT AND LEADERSHIP  
LEADERSHIP AND MANAGEMENT

**PUBLIC HEALTH IMPROVEMENT AND LEADERSHIP**

**LEADERSHIP AND MANAGEMENT**

**OFFICE OF MINORITY HEALTH**

<b>GOAL 1: PREPARE MINORITY MEDICAL, VETERINARY, PHARMACY, AND GRADUATE STUDENTS FOR CAREERS IN PUBLIC HEALTH.</b>			
<b>Measure</b>	<b>FY</b>	<b>Target</b>	<b>Result</b>
1. Increase the number of minority students participating in the Hispanic Serving Health Professions Internship and Fellowships Program, Ferguson Emerging Infectious Disease Fellowship Program, Public Health Summer Fellowship Program, Research Initiatives for Student Enhancement (RISE) and Project IMHOTEP.	2008	95	8/2008
	2007	87	8/2007
	2006	87	91(Exceeded)
	2005	95	101 (Exceeded)
	2004	92	95 (Exceeded)
	2003	65	74 (Exceeded)

**Data Source:** The data source is based on the number of interns and fellows who are core-funded.

**Data Validation:** Data quality assurance is measured by review of quarterly and annual program progress reports.

**Cross Reference:** 500-1

**Goal 1, Performance Measure 1:**

CDC surpassed the FY 2006 target to enroll 87 students in four summer training programs designed to encourage minority students to pursue graduate careers in public health and to diversify the public health workforce. Demographic data are compiled for all student training programs annually. New cooperative agreements competed under Kennedy Krieger Institute/RISE, Morehouse College/IMHOTEP, program announcements yielded more students than targeted. Collaborative and coordinated efforts among funded programs enhanced student enrollment in the summer training programs by expanding and extending the categorical program areas (i.e., medical, pharmacy, veterinary) and activities to include all Historically Black Colleges and Universities (HBCUs) with health professions schools. Coordinated efforts also provided opportunities for 12 additional students, via affiliated programs, that supported this goal.

<b>GOAL 2: SUPPORT HBCUS AND HISPANIC SERVING INSTITUTIONS.</b>			
<b>Measure</b>	<b>FY</b>	<b>Target</b>	<b>Result</b>
1. Increase the number of funding mechanisms and the number of minority-serving institutions receiving support.	2008	4 cooperative agreements; 50 schools	8/2008
	2007	4 cooperative agreements; 47 schools	8/2007
	2006	4 cooperative agreements; 47 schools	4 cooperative agreements; (Met) 48 schools (Exceeded)
	2005	5 cooperative agreements; 75 schools	4 cooperative agreements (Unmet); 76 schools (Exceeded)
	2004	4 cooperative agreements; 69 schools	4 cooperative agreements (Met); 70 schools (Exceeded)
	2003	4 cooperative agreements; 67 schools	4 cooperative agreements (Met); 70 schools (Exceeded)

**Data Source:** The data source is based on the number of interns and fellows who are core-funded.

**Data Validation:** Data quality assurance is measured by review of quarterly and annual program progress reports.

**Cross Reference:** 500-1

**Goal 2, Performance Measure 1:**

The FY 2006 performance goal to award four cooperative agreements to support Historically Black Colleges and Universities (HBCUs), and Hispanic Serving Institutions was achieved. In FY 2006, a total of 48 schools were reached, exceeding the 2006 target by one school. The targeted number of institutions projected for FY 2007 and FY 2008 were decreased because the Tribal Colleges and Universities cooperative agreement, representing 33 institutions, expired at the end of FY 2005. CDC continues to strengthen its efforts to expand and diversify partnerships with academic institutions and to increase the competence and diversity of the public health workforce.

<b>GOAL 3: FOSTER A STRONGER COLLECTIVE DEPARTMENTAL PERSPECTIVE ON AI/AN ISSUES.</b>			
Measure	FY	Target	Result

1. Working in conjunction with IHS, identify and pursue areas of mutual interest and benefit.	2006	1 Senior Policy Workgroup meeting	Unmet
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areas of mutual interest and benefit.	2005	1 Senior Policy Workgroup meeting	Unmet
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**Data Source:** Communication between CDC/IHS senior management staff and summaries of workgroup meetings; project reports from CDC-IHS IAAs, official meeting summaries, documented activities (i.e., trainings, workshops), collaborative efforts, and CDC Financial Management Office tracking of resources allocated to IHS and tribal programs.

**Data Validation:** Data quality assurance is measured by review of senior staff workgroup meeting summaries, epidemiological data sources, program progress reports, and documented outcome of collaborative efforts. All data sources are reviewed by CDC Senior Tribal Liaisons and CDC senior management (OD/OSI/OMHD).

**Cross Reference:** 500-1

**Goal 3, Performance Measure 1:**

During 2006, it was determined that there would be no specific Senior Policy Workgroup meeting, rather CDC and IHS senior staff would collaborate on important issues on a regular basis to maximize resources and services going to AI/AN tribes. The agencies continued to have multiple teleconferences on issues such as STD/HIV, Diabetes, closing the gap on infant mortality, pandemic influenza planning, and terrorism preparedness and response. In addition, CDC initiated discussions to strengthen IHS-CDC partnerships through the development of an umbrella Interagency Agreement (IAA) with the National Center for Health Marketing and IHS. This IAA will assist multiple CDC Centers, Offices and Divisions to have one agreement that establishes consistent measures and reporting requirements while still allowing flexibility for different programs. CDC is examining the development of a new measure focusing on AI/AN activities. Therefore, the utilization and implementation of this measure will be assessed for future use, pending an FY 2006 assessment and the availability of funding. CDC is examining the development of a new measure focusing on AI/AN activities. Therefore, the utilization and implementation of this measure will be assessed for future use, pending an FY 2006 assessment and the availability of funding.

<b>GOAL 4: SUPPORT AND STRENGTHEN CAPACITY DEVELOPMENT STRATEGIES OF EXISTING NATIONAL AND REGIONAL MINORITY ORGANIZATIONS.</b>			
Measure	FY	Target	Result

1. Increase the number of national and regional public health collaborations with public health agencies/organizations serving minority communities via the delivery of culturally-proficient and linguistically-appropriate public health services and by developing, promoting, and marketing health promotion and professional training and educational programs and materials.	2008	100	10/2008
	2007	85	10/2007
	2006	75	477 (Exceeded)
2. Identify program and organizational infrastructure needs (i.e., policy analysis, program assessment and development, and evaluation) of public health agencies/organizations serving minority communities and provide technical assistance to improve the health status and access to programs for racial and ethnic minority populations.	2008	100	10/2008
	2007	85	10/2007
	2006	75	477 (Exceeded)

**Data Sources:** The data sources are based on the number of collaborative efforts, documented activities (i.e., trainings, workshops, coalition building and collaboration, leadership development, services), developed and implemented products (i.e., curriculums, guidance,), and the amount of innovative capacity building assistance (i.e., management, fiscal management, programs operations) that are provided to public health agencies/organizations serving minority communities annually.

PERFORMANCE DETAIL  
PUBLIC HEALTH IMPROVEMENT AND LEADERSHIP  
LEADERSHIP AND MANAGEMENT

<b>Data Validation:</b> Data quality assurance is measured by review of quarterly and annual program progress reports, and documented outcome of key program activities.
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<b>Cross Reference:</b> 500-1
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**Goal 4, Performance Measures 1 and 2:**

FY 2006 data shows that CDC has surpassed targets for both measures to support and strengthen the capacity development strategies of existing National and Regional Minority Organizations for FY 2006. All programs have histories of providing direct or indirect service to minority and high-risk populations through a community-based approach and proven delivery system channels. They support national and/or regional initiatives to develop, expand, and enhance health promotion, educational, and community-based programs targeting racial and ethnic populations. Once funding was in place, current infrastructures and national networks allowed provided grantees with multiple mechanisms to exceed the anticipated target for Measure 1. They also allowed programs to quickly identify a multitude of program and organizational infrastructure needs relevant to Measure 2.

Final results of the FY 2007 performance goal measures for the seven cooperative agreements awarded to support and strengthen existing National and Regional Minority Organizations (NMOs/RMOs) that engage in health advocacy, promotion, education and preventive health care with the intent of improving the health and well-being of racial and ethnic minority populations will be available in October 2007.

## PUBLIC HEALTH WORKFORCE DEVELOPMENT

Efficiency Measure	FY	Target	Result
1. Increase the efficiency with which the OMB Clearance package for Epi-Aids is processed, resulting in reduced number of staff hours spent in preparing the package for submission. [E]	2006	50 hours	12/2007
	2005	50 hours	18 hours (Met)
	2004	50 hours	22 hours (Met)
	2003	Baseline	200 hours

**Data Source:** Program Analyst monitors completion of Epi-Aid trip reports which includes the OMB reporting form.

**Data Validation:** Completion and submission of triennial report to OMB.

**Cross Reference:** HHS-8, HP-23

### **Efficiency Measure 1:**

This measure focuses on increasing the efficiency with which the OMB Clearance package for Epi-Aids is processed. It will result in reduced number of staff hours in preparing the package for submission and tracking the results of Epi-Aids. In 2004, the number of staff hours spent on preparing the package was 22 hours, based on 15 minutes/Epi-Aid to review 90 Epi-Aid reports to ensure the OMB reporting form is included. In FY 2005, the number of staff hours spent on preparing the package was 18 hours, based on 15 minutes/Epi-Aid to review 72 Epi-Aid reports to ensure the OMB reporting form is included. The OMB Clearance package is prepared and submitted every three years; the most recent submission was December 2006. Now that the data for FY 2006 have been reported, the measure is retired and will not be reflected in future performance detail. The current measure is based on where the Office of Workforce and Career Development is located within the CDC budget submission. A new measure will be developed in its place.

<b>GOAL 1: CDC WILL DEVELOP AND IMPLEMENT TRAINING TO PROVIDE FOR AN EFFECTIVE, PREPARED, AND SUSTAINABLE HEALTH WORKFORCE ABLE TO MEET EMERGING HEALTH CHALLENGES.</b>			
Measure	FY	Target	Result
1. Increase the number of local, state, and federal health professionals who participate in training in epidemiology or public health leadership management.	2008	200	12/2009
	2007	200	12/2008
	2006	200	12/2007
	2005	200	216 (Exceeded)
	2004	200	221 (Exceeded)

**Data Source:** Currently, data are based on the number of fellows (EIS, PHPS, PMR) that are core funded.

**Data Validation:** Staff reviews and validates data through the program's personnel system.

**Cross Reference:** HHS-2, 4, HP-23, 500-1

### **Goal 1, Performance Measure 1:**

In a response to an August 2003 report that identified gaps at the state and local levels, CDC continues to train professional staff to address these gaps and investigate health problems affecting the nation's population.

- EIS officers participate in domestic and international infectious disease investigations.
- Preventive Medicine Residency combines clinical medical skills with public health practice expertise (e.g., epidemiology, health services management, environmental health).
- Public Health Prevention Service Program focuses on public health program management and provides experience in program planning, implementation, and evaluation through specialized hands-on training and mentorship at CDC and in state and local health agencies.

## PUBLIC HEALTH WORKFORCE DEVELOPMENT

The 2004 result was revised from 258 to 221 to reflect fellows that were core-funded in FY 2004. The previous result inadvertently included EIS officers funded with non-core funds (e.g., Bioterrorism, Food Safety). Additionally, the 2005 through 2008 targets have been revised to remain constant, due to the creation of the Office of Workforce and Career Development in 2004 and uncertainty about funding limiting programmatic ability to increase the number of health professionals recruited and/or trained.

**GOAL 2: INCREASE THE NUMBER OF FRONTLINE PUBLIC HEALTH WORKERS AT THE STATE AND LOCAL LEVEL THAT ARE COMPETENT AND PREPARED TO RESPOND TO BIOTERRORISM, INFECTIOUS DISEASE OUTBREAKS, AND OTHER PUBLIC HEALTH THREATS AND EMERGENCIES; AND PREPARE FRONTLINE STATE AND LOCAL HEALTH DEPARTMENTS AND LABORATORIES TO RESPOND TO CURRENT AND EMERGING PUBLIC HEALTH THREATS.**

Measure	FY	Target	Result
1. Evaluate the impact of training programs conducted by the NLTN on laboratory practices.	2008	<b>Same at FY 2006 target</b>	12/2008
	2007	<b>Same as FY 2006 target</b>	12/2007
	2006	90% of the public health and clinical laboratorians attending NLTN courses can correctly handle, process, or identify potential disease agents.	CDC met this target by offering the Focus on Biosecurity Practices course (Met)
	2005	Reduce rejection rates of specimens submitted to state laboratories for newborn screening as a result of training.	Results Inconclusive (Unmet)
	2004	Assess the increase in the number of laboratories that adopt specific NCCLS practices for antimicrobial susceptibility testing and reporting.	34% increase (Baseline) (Met)
<b>Data Source:</b> Data for the FY 2006 – FY 2008 targets are related to laboratory safety and security. The data are collected following each course, reviewed, and evaluated by a statistician.			
<b>Data Validation:</b> Data are reviewed by the CDC Training Advisor responsible for the course. Collective data are checked quarterly.			
<b>Cross Reference:</b> HHS-2, 4, 5, HP-23			

**Goal 2, Performance Measure 1:**

The National Laboratory Training Network (NLTN) conducted 255 training courses and trained more than 27,000 participants through cost-effective, high quality continuing education in the laboratory sciences during the FY 2006. NLTN courses are available in a variety of formats, developed based on documented training needs, and delivered in collaboration with state public health laboratories. Course topics include bioterrorism and chemical terrorism preparedness, safe packaging and shipping of diagnostic and infectious agents, biosafety and biosecurity, antimicrobial susceptibility testing, and pandemic influenza preparedness. Selected courses from the previous year are evaluated to determine outcomes of training.

The FY 2006 target related to safety and security in the laboratory were met at 90 percent. Between January and April 2006, 324 participants from 13 states attended NLTN courses in laboratory biosecurity practices, which included information on physical security access control, information security, and training/practice drills. Additionally, a comparison of pre and post test scores showed that 226 (73.6 percent) of course participants improved their knowledge of biosecurity practices. Six months following the training, 9 (2.7 percent) of participants reported writing a biosecurity plan for their laboratory for the first time. Thirty-nine (12 percent) of course participants reported implementing positive changes in their facility in at least one of the biosecurity practice areas listed above.

This training and gathering of statistical data will continue during FY 2007.

**PREVENTIVE HEALTH AND HEALTH SERVICES BLOCK GRANT**

<b>EFFICIENCY GOAL: PROVIDE DYNAMIC SUPPORT FOR HIGH PRIORITY STATE AND LOCAL DISEASE PREVENTION AND HEALTH PROMOTION PROGRAMS.</b>			
<b>Efficiency Measure</b>	<b>FY</b>	<b>Target</b>	<b>Result</b>
1. Eliminate the hours it takes to install GARS (Grants Application and Reporting System) software on grantees machines by establishing a Web-based system. [E]	2005	0 hours	12/2007
	2004	GARS becomes web-based	30% implemented (Unmet)
<b>Data Source:</b> Data logs that track log-ins to the web-based application.			
<b>Data Validation:</b> Information is electronically verified prior to transmission to CDC.			
<b>Cross Reference:</b> HHS-8			

**Efficiency Measure 1:**

A non-web-based Grants Application and Reporting System (GARS) is burdensome and inefficient for states and CDC. This burden is exacerbated as states face deep budget cuts. State health departments will save 1,952 hours per year on project reporting by using a Web-based GARS (1,952 grantee hours equals an average of four system per grantee times 61 grantees times eight hours per installation). CDC will save 720 hours, for a total saving of 2,672 hours.

The FY 2007 President's Budget proposed elimination of the Preventive Health and Health Services Block Grant. Therefore, CDC implemented only thirty percent of the highest-priority components of the system by December 2005. Given the inclusion of the PHHS Block Grant in FY 2006 budget and the indication that the program will be continued through a continuing resolution for FY 2007, CDC is proceeding with development and installation of the remaining web-based modules to make GARS fully web-based. The software development is on track at 55 percent completion. A partial implementation is planned for September 2007 and full implementation is scheduled to be completed by December 2007.

## BUILDINGS AND FACILITIES

In addition to PART measures established in the 2004 review of Buildings and Facilities, CDC has implemented HHS-level Federal Real Property Council (FRPC) performance metrics. CDC used the following measures and definitions detailed in the memo, HHS Real Property Asset Management Program Performance Measures (DAS/OFMP, 8 SEP 2005), to assess its FY 2008 B&F budget submission described in the attached Program Narrative, as directed in the memo, Pre-Budget Guidance for the HHS Fiscal Year 2008 Budget (DAS/OFMP, 30 MAR 2006).

- Mission Dependency – An indication of the value an asset brings to the performance of the HHS/OPDIV mission.
- Facility Utilization – A quantitative assessment of the degree to which assets are utilized by asset type, including “Utilization Status,” “Utilization Rate,” and “Disposition Recommendation.”
- Facility Condition – A quantitative assessment of how well an asset is being maintained in accordance with a systematic Sustainment and Improvement Strategy.
- Facility Cost – An assessment of the total operating and maintenance costs at the asset level, and positive project economics such as cash-flow or life-cycle cost analysis.

### FRPC Performance Metrics

Nationwide Repairs and Improvements (R&I) Program		
FRPC Measure	Impact	Explanation
<b>Mission Dependency</b>		
Mission Dependency	Positive	R&I funds will be used for "mission critical" and "mission dependent" facilities in accordance with CDC's Sustainment strategy. Repair funds are used to sustain buildings in an "operational status." Improvement funds are used to modify space to bring it into alignment with current codes and reduce "overutilized" space.
<b>Facility Utilization</b>		
Utilization Status	Positive	R&I funds will be used for "overutilized" and "utilized" facilities in accordance with CDC's sustainment strategy.
Utilization Rate	Positive	R&I funds are used to restore assets to a condition that allows their continued effective designated use, and to improve an assets functionality or efficiency, thus maintaining or improving the utilization of the asset.
Retention/Disposal	Positive	CDC intends to use R&I funds to demolish part of 45 identified underutilized, non-mission critical, underperforming assets between 2006-2010, that are not funded through major (Capital) projects, thereby improving portfolio utilization rates and reducing costs. An additional 13 assets have been identified for disposal by 2013.
Facility Condition	Positive	As shown in the Facility Condition Index table, R&I funding at these levels will support CDC's sustainment strategy to maintain portfolio CI=90 or better.
Sustainment and Improvement Strategy	Positive	CDC has a current (2006) estimated Building Maintenance Backlog Reduction (BMAR) of \$61 million. At the R&I funding levels detailed in the Facility Condition Index Table, CDC will reduce BMAR by \$11.3M to achieve a minimum portfolio CI=90 by FY 2013.
<b>Facility Cost</b>		
O&M Cost	Positive	CDC anticipates a positive but unquantified impact on O&M costs resulting from sustainment-level R&I funding. Appropriate R&I and BSS funding will ensure that plant and equipment are operated and maintained in accordance with manufacturer's warranties, and to maximize energy and operating efficiencies.
Project Economics	N/A	

Sustainment Strategy Summary: Sustainment funding includes a combination of operations funded maintenance and minor renovations, and B&F funded repair, necessary to sustain the facility in its current condition. CDC funds sustainment through the internal Business and Services Support (BSS) activity (operations) and the nationwide Repairs and Improvements (R&I) Program (B&F).



Using data from the Automated Real Property Information System data base and individual Building Condition Assessments, CDC has projected R&I and BSS funding required from FY 2008 to FY 2013 inclusive, to improve and sustain CDC's owned assets at a minimum Condition Index (CI) of 90 as required by HHS. These projections take into account assets that CDC will propose to HHS for disposal based on the FRPC Disposition Decision Tree, as well as new assets approved, funded and under design/construction through FY 2006, and proposed assets identified in the Five-Year Plan with an out-year cost estimate (i.e., B24, B107, B108, and build-out of the Ft. Collins lab shell space). CDC's sustainment strategy incorporates the following measures:

- Base funding requests on periodically updated Facility Condition Assessments for each asset to achieve and maintain a minimum CI=90;
- Prioritize sustainment funding around mission critical assets that are appropriately utilized and can be operated and maintained in a cost effective manner;
- Continue to review the owned and leased inventory to identify assets for disposition in accordance with the FRPC's Disposition Decision Analysis framework (Please note that since the late 1990's, CDC has disposed of or earmarked for disposal over 40 non-performing assets nationwide); and,
- Continue to request recapitalization funding for new construction or modernization where appropriate to replace non-performing assets as described in the 5-Year Plan in the narrative section.

#### PART Performance Measures

Efficiency Measure	FY	Target	Result
1. Energy and water reduction. [E]	2008	Energy 20%; Water 30%	12/2008
	2007	Energy 20%; Water 30%	12/2007
	2006	Energy 20%; Water 30%	Energy 15% reduction; (Unmet) Water +30% (Met)
	2005	Energy 20%; Water 15%	Energy 18% reduction; Water +9% (Unmet)
	2003	Baseline	Energy 8% reduction; Water 19% reduction
2. Deliver leased space below Atlanta's sub-market rate. [E]	2008	<b>10% under market</b>	10/2008
	2007	10% under market	10/2007
	2006	10% under market	-10% (Met)
	2005	10% under market	-10% (Met)
	2003	Baseline	5% under market
<b>Data Source:</b> Measure 1 - CDC-monitored utility meters at Campus or building level, and utility bills; <b>Measure 2</b> - GSA Rent bills, CDC market surveys, and commercially available data sources such as Black's Guide and CoStar.			
<b>Data Validation:</b> <b>Measure 1</b> - Meters are owned and validated by the utility, and are checked monthly; <b>Measure 2</b> - Market surveys are conducted no less than monthly and verified against GSA and commercially available data that serves as "benchmark" data for private industry.			
<b>Cross Reference:</b> <b>Measure 1 and 2</b> – PART			

#### Efficiency Measure 1:

In response to Executive Order #13123 identifying specific energy reduction goals and applying water management strategies, CDC has initiated monitoring and strategic planning efforts to ensure full compliance with the Executive Order and internal water management standards.

CDC has met 75 percent of its energy goal. CDC is placing considerable emphasis on energy efficient design for its new labs, and this may result in lower future consumption. However, CDC may expect somewhat higher energy usage through the end of the projected construction period [FY 2009] as some older labs remain in service combined with additional electrical usage resulting from actual construction activities. CDC is working with HHS to bring the water metric in line with Executive Order #13123.

**Efficiency Measure 2:**

To demonstrate the most efficient use of taxpayer dollars, this measure will monitor leased space cost with the expectation of delivering quality space below sub-market rates. CDC used its market presence and sound negotiations to achieve below market lease rates.

<b>GOAL 1: IMPLEMENT SCHEDULED IMPROVEMENTS, CONSTRUCTION, SECURITY, AND MAINTENANCE CONSISTENT WITH AVAILABLE RESOURCES AND PRIORITIES IDENTIFIED IN CDC'S MASTER FACILITIES PLANNING PROCESS.</b>			
<b>Measure</b>	<b>FY</b>	<b>Target</b>	<b>Result</b>
1. Aggregate of scores for capital projects rated on scope, schedule, budget, and quality.	2008	<b>Greater than or equal to 90%</b>	10/2008
	2007	Greater than or equal to 90%	10/2007
	2006	Greater than or equal to 90%	=>90% (Met)
	2005	Greater than or equal to 90%	=>90% (Met)
		<b>Royal Campus</b> East Campus Consolidated Lab Project, Bldg 23	<b>Royal Campus</b> East Campus Consolidated Lab Project, Bldg 23
	2008	<b>Continue construction</b>	6/2008
	2007	Complete design, Continue construction	6/2007
	2006	Continue design, Begin construction	Met
	2005	Continue design	Met
	2004	Begin design (Pending Project and Funding Authority Approval)	Met (Pending Project and Funding Authority Approval)
		Epi Tower, Bldg 24	Epi Tower, Bldg 24
	2008	<b>Pending</b>	TBD
	2007	Pending	TBD
	2006	Pending (Pending Project and Funding Authority Approval)	TBD (Pending Project and Funding Authority Approval)
	2005	Begin design (Pending Project and Funding Authority Approval)	Pending (Pending Project and Funding Authority Approval)
	2004	Begin design (Pending Project and Funding Authority Approval)	Pending (Pending Project and Funding Authority Approval)
		HQ & Emergency Ops Center, Bldg 21	HQ & Emergency Ops Center, Bldg 21
	2005	Complete construction	Met
	2004	Begin construction	Met
	2003	Complete design	Met
		Infrastructure and security upgrades, Bldg 20	Infrastructure and security upgrades, Bldg 20
	2008	Complete Construction	6/2008
	2007	Continue construction	6/2007
	2006	Continue construction	Met
	2005	Continue construction	Met

**GOAL 1: IMPLEMENT SCHEDULED IMPROVEMENTS, CONSTRUCTION, SECURITY, AND MAINTENANCE CONSISTENT WITH AVAILABLE RESOURCES AND PRIORITIES IDENTIFIED IN CDC'S MASTER FACILITIES PLANNING PROCESS.**

Measure	FY	Target	Result
		Scientific Communications Center, Bldg 19	Scientific Communications Center, Bldg 19
	2005	Complete construction	Met
	2004	Continue construction	Met
	2003	Begin construction	Met
		Emerging Infectious Disease Lab, Bldg 18	Emerging Infectious Disease Lab, Bldg 18
	2005	Complete construction	Met
	2004	Continue construction	Met
	2003	Continue construction	Met
		<b>Chamblee Campus</b> Environmental Health Facility, Bldg 106	<b>Chamblee Campus</b> Environmental Health Facility, Bldg 106
	2007	Complete Construction	6/2007
	2006	Complete design; Continue construction	Met
	2005	Begin design, Begin construction	Met
	2004	Design target adjusted to FY 2005	Met
		Environmental Toxicology Lab, Bldg 110	Environmental Toxicology Lab, Bldg 110
	2005	Complete construction	Met
	2004	Continue construction	Met
	2003	Continue construction	Met
		<b>Cincinnati Campus</b> Lab Consolidation – Site Acquisition	<b>Cincinnati Campus</b> Lab Consolidation – Site Acquisition <sup>1</sup>
	2008	Continue analyses	10/2008
	2007	Continue analyses	10/2007
	2006	Continue analyses	Met (Pending Project and Funding Authority Approval) <sup>1</sup>
	2005	Continue analyses	Met (Pending Project and Funding Authority Approval) <sup>1</sup>
	2004	Conduct analyses	Met (Pending Project and Funding Authority Approval) <sup>1</sup>

**GOAL 1: IMPLEMENT SCHEDULED IMPROVEMENTS, CONSTRUCTION, SECURITY, AND MAINTENANCE CONSISTENT WITH AVAILABLE RESOURCES AND PRIORITIES IDENTIFIED IN CDC'S MASTER FACILITIES PLANNING PROCESS.**

Measure	FY	Target	Result
		<u>Ft. Collins, CO Campus</u>	<u>Ft. Collins, CO Campus</u>
	2007	Complete construction	2/2007
	2005	Continue construction	Met
	2004	Complete design; begin construction	Met
2. Placement of NCID & NCEH laboratorians in CDC standard space (Projects occupied or underway).	2008	<b>NCID 70%; NCEH 100%</b>	10/2008
	2007	NCID 70%; NCEH 100%	10/2007
	2006	NCID 70%; NCEH 100%	70%, 100% (Met)
	2005	NCID 70%, NCEH 100%	70%, 100% (Met)
3. Relationship of work orders (scheduled and unscheduled maintenance).	2008	<b>Scheduled 95%; Unscheduled 5%</b>	10/2008
	2007	Scheduled 95%; Unscheduled 5%	10/2007
	2006	Scheduled 95%; Unscheduled 5%	95%, 5% (Met)
	2005	Scheduled 95%, Unscheduled 5%	95%, 5% (Met)
<b>Data Source:</b> <u>Measure 1</u> - Project Management Plans and Facility Project Approval Agreements; <u>Measure 2</u> - Facility Condition Index and periodic employee census counts; <u>Measure 3</u> - "The Management System (TMA)" tracking reports.			
<b>Data Validation:</b> <u>Measure 1</u> - On-site validation in daily or weekly meetings with Project Managers and Contractors verified against approved project management plans and contractual schedule of deliveries and payments; <u>Measure 2</u> - Verification or personnel counts with end-users when the buildings come on line, with additional verification through bi-annual building census. Laboratory "standard" verified through periodic (3-5 year) reviews of Facility Condition Index against published CDC laboratory and construction guidelines (Biosafety in Microbiological and Biomedical Laboratories, and CDC Design and Construction Standards); <u>Measure 3</u> - Tracking performed at the work order level through TMA, with monthly verification by operations & maintenance inspection personnel.			
<b>Cross Reference:</b> <u>Measure 1</u> – PART; <u>Measure 2</u> - PART; <u>Measure 3</u> – PART			

<sup>1</sup> Project approved by the HHS Capital Investment Review Board to proceed with only analyses needed to support project. The project has not been approved for execution and funding beyond the analysis portion. CDC is continuing with the analyses as approved.

**Goal 1, Performance Measure 1:**

The aggregate scoring of four vital components (scope, schedule, cost and quality) of capital construction will most accurately assess successful performance and use of appropriated funds. The four combined components provide a comprehensive snapshot of capital construction. Scope, schedule, cost and quality are identified and approved consistent with the Facilities Project Approval Agreement process. The scope component will identify the predefined project needs; the schedule component will reflect the critical milestone dates; the cost component will establish the approved project budget; and the quality component will incorporate the scoring reflecting the use of appropriate building standards and codes.

**Goal 1, Performance Measure 2:**

The movement of CDC laboratorians into CDC standard space will facilitate CDC's ability to meet its scientific mission. CDC standard space includes standards for bio-safety, CDC design, space planning, and accreditation of laboratory animal care and HHS utilization rate policy. This metric has underlying assumptions concerning the stability of CDC's growth rates, workforce composition, laboratory standards, and applicable codes. Any significant changes in baseline assumptions would require appropriate upward/downward adjustments to target rates.

By moving select components of the National Center for Infectious Diseases (NCID) into Building 18, the Emerging Infectious Disease Laboratory, CDC met its goal of 70 percent occupancy by NCID for 2005.

This building houses the Division of Bacterial and Mycotic Diseases (DBMD), the Division of Viral and Rickettsial Diseases (DBMD), the Division of HIV/AIDS Prevention (DHAP), HIV and Retrovirology Branch, and the Division of Viral Hepatitis (DVH). Building 18 contains unique high containment laboratory space to support research on hazardous pathogens such as Ebola, Avian Flu, and SARS. The facility is also the central receiving, processing and response lab for the CDC Bioterrorism Preparedness and Response Program and Rapid Response/Advanced Technology Lab.

With the occupancy of Building 110, the Environmental Toxicology Laboratory, CDC met 100 percent of its 2005 goal to move the National Center for Environmental Health (NCEH) into CDC standard space. This facility houses the Division of Laboratory Sciences (DLS) whose employees use advanced laboratory science and innovative techniques to prevent disease from exposure to toxic chemicals in the environment; respond to terrorism and public health emergencies involving chemicals; and improve laboratory methods to diagnose and prevent disease. Scientists are working on developing a breakthrough test for botulinum and other toxins. The Radionuclide Laboratory measures select radionuclides that might result from "dirty bombs" or other releases. CDC's award-winning Newborn Screening Quality Assurance Program is the only source in the world for ensuring the accuracy of newborn screening tests responsible for identifying thousands of babies each year who are born with genetic or metabolic disorders. In addition, Building 110 serves as the home of the world reference laboratory for measuring cholesterol, triglycerides, and high and low-density lipoproteins.

**Goal 1, Performance Measure 3:**

This measure will track the percentage of maintenance projects that are scheduled (i.e., planned) to maintain the facilities, versus the percentage of unscheduled work orders tied to repairs of non-functioning or faulty systems. In general, all facilities are better protected through scheduled maintenance.

## TERRORISM

CDC's Upgrading CDC Capacity and Biosurveillance programs underwent the OMB PART process in 2006. As a result of the PART process, CDC developed new performance measures, including long-term outcome measures, annual outcome and output measures and an efficiency measure. This document reflects the additional measures adopted as a result of the PART process.

EFFICIENCY GOAL: CREATE PROGRAM EFFICIENCIES THAT IMPROVE SERVICES AND CONSERVE RESOURCES FOR MISSION CRITICAL ACTIVITIES.			
Efficiency Measure	FY	Target	Result
1. Fully automate the application, work plan and semi-annual reporting for cooperative agreement grantees to achieve greater program efficiencies. [E] (This measure will be retired and replaced by measure 2 below)	2006	62 grantees	62 grantees using system (Met)
	2005	62 grantees using system	61 grantees using system (Unmet)
	2003	Baseline	57 grantees using the system, with limited functionality
2. Decrease the amount of time it takes the Division of State and Local Readiness (DSLR) Project Development Officers to conduct technical reviews of work plans and budgets for all 62 grantees by providing appropriate tools and functionality in the DSLR Management Information System (MIS).	2008	25 days	12/2009
	2007	28 days	12/2008
	2006	Baseline	30 day
3. Dollars saved per \$1 invested in the Food and Drug Administration's (FDA) Shelf Life Extension Program (SLEP) for available projects. [E]	2008	<b>\$28</b>	12/2008
	2007	\$26	12/2007
	2006	\$24	\$20 (Unmet)
	2005	Baseline	\$22
4. Decrease annual costs for personnel and materials development with the development and continuous improvement to the budget and performance integration information system tools. [E]	2008	<b>\$0/ BPI and Health Impact system</b>	12/2008
	2007	\$50,000/ BPI and Health Impact system	12/2007
	2006	N/A	\$86,800/BPI and Health Impact system
	2005	N/A	\$101,000/Budget and Performance Integration (BPI) system
	2004	Baseline	\$125,000/Excel system
<b>Data Source:</b> Measure 1 - CDC's Coordinating Office of Terrorism Preparedness and Emergency Response has maintained a management information system on CDC's Secure Data Network (SDN) for approximately three years. This system, known as SLPP-MIS, is used to receive, process, monitor, and evaluate cooperative agreements of over \$750 million per year for 62 grantees. Measure 2 – CDC's Coordinating Office of Terrorism Preparedness and Emergency Response has maintained a management information system on CDC's Secure Data Network (SDN) for approximately three years. This system, known as SLPP-MIS, is used to receive, process, monitor, and evaluate cooperative agreements of over \$750 million per year for 62 grantees. Measure 3 - CDC's SNS analysis of product Life Cycle Tools. Measure 4 - COTPER has been at the forefront of development of two information technology tools for budget and performance integration. These tools are now widely used by a variety of staff for a variety of purposes, including gaining efficiencies in the consolidation of information systems, and reducing the time required to find, collate, and use data.			
<b>Data Validation:</b> Measure 1 - There is an internal tracking system component of SLPP-MIS called Enhanced Project Management (EPM) that is utilized by each of the CDC DSLR project officers, as well as senior staff, to track and maintain project issues, comments, progress, and provide reporting functionality on each of the 62 grantees. Measure 2 – When the technical review process begins, the date/ time will be noted in the system; Once the target date/time is reached, the system will be closed and Project Officers will not be able to conduct additional technical reviews. Measure 3 - CDC's SNS coordinates with the FDA and maintains an internal tracking system for identification of products that may be eligible for the SLEP. Measure 4 –Health Impact and IRIS B&PI are used to track annual costs for personnel and materials development.			
<b>Cross Reference:</b> Measure 1 - HHS-8, -3, 4, 500-4; Measure 2 - 500-4; Measure 3 - PART, 500-4; Measure 4 -PART, 500-4			

**Efficiency Measure 1:**

In 2006, all 62 newly funded grantees used the system to fully automate their applications, work plans, and semi-annual reporting for the CDC Terrorism Preparedness cooperative agreement, resulting in greater program efficiencies. The Marshall Islands territory did not submit an application and was not provided new funding. Currently, all 62 grantees are using the system for self-reporting and reports were received in May and November 2006. The benefits of the system and new supporting processes have improved timeliness of applications, ease of processing and production for review as well as elimination of paper processing. Additionally, development of the system addresses the e-government provisions of the President's Management Agenda. Now that the data for FY 2006 have been reported, the measure is retired and will not be reflected in future performance detail. A new efficiency measure has been developed.

**Efficiency Measure 2:**

CDC's DSLR is responsible for providing management oversight and technical assistance for the administration of the Public Health Emergency Preparedness Cooperative Agreement. As part of the application process, grantees have to submit detailed work plans and budgets which can total 100 pages each. CDC Project Development Officers (PDO) need to review, provide feedback, and approve applications before funds can be awarded. In addition, at the end of the extensive review process, PDOs provide recommendations for each work plan activity and line items are restricted or disallowed for the budget. The issues cited during this review need to be monitored and resolved during the year.

Historically, PDOs conducted technical reviews of the grants using paper-based approaches. This resulted in cumbersome paperwork and difficulty in tracking resolution of issues raised during the review process. To deal with these operational limitations, CDC's Management Information System (MIS) was enhanced to centralize the collection, tracking and management of review information. MIS not only maximizes efficiency of the initial application review, but helps facilitate technical assistance efforts throughout the course of the year. The automation and integration of this process will create overall efficiencies in the grants management process by decreasing the time it takes for PDOs to conduct initial reviews and by providing rapid access to information to track and manage over time.

The efficiency gained from the integration of the review section into the MIS translates into other efficiencies from the grantees' standpoint including:

- Reduces the time that it takes grantees to get feedback regarding their work plans and budgets from Project Officers. This in turn results in a faster implementation of recommended changes thereby improving the overall efficiency of their programmatic operations.

**Efficiency Measure 3:**

This efficiency measure was adopted during the PART process to demonstrate the program's improved efficiencies. The return on investment (ROI) is based on each \$1 spent on SLEP costs (e.g., testing, shipping, re-labeling). For FY 2006, the \$20 was saved for each \$1 spent on SLEP costs, falling short of the goal of \$24 saved. This ROI is calculated based on the total estimated replacement costs divided by the total estimated SLEP costs. For the baseline, CDC used 10 FDA SLEP projects submitted in FY 2004.

**Efficiency Measure 4:**

As systems continue to improve, the goal is to gradually decrease the time and material costs required by contractors while not impacting the quality and timeliness of work developed and delivered.

**PREVENTION**

Preparedness goal one (Increase the use and development of interventions known to prevent human illness from chemical, biological, radiological agents and naturally occurring health threats) does not currently have supporting PART or GPRA performance measures.

**DETECTION AND REPORTING**

PREPAREDNESS GOAL 2: DECREASE THE TIME NEEDED TO CLASSIFY HEALTH EVENTS AS TERRORISM OR NATURALLY OCCURRING IN PARTNERSHIP WITH OTHER AGENCIES.			
Measure	FY	Target	Result
1. 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.	2008	3,800	12/2008
	2007	3,400	12/2007
	2006	3,200	4,220 (Exceeded)
	2005	3,000	3,300 (Exceeded)
	2004	2,100	2,812 (Exceeded)
2. Number of top 50 metropolitan areas using BioSense. [O]	2008	50	12/2008
	2007	50	12/2007
	2006	40	38 (Unmet)
	2005	Baseline	10
3. By 2010, the BioSense program will reduce the time needed from a triggering biosurveillance event (the identification of a potential disease event or public health emergency event) to initiate event-specific standard operating procedures (the initiation of a public health investigation and, if needed, subsequent public health intervention) for all infectious, occupational or environmental (whether man-made or naturally occurring) threats of national importance. [O]	Targets Under Development		
<b>Data Source:</b> CDC's Epi-X network tracks the number of state and local public health professional that use the system. <u>Measure 2 - BioSense</u> application tracks the number of members and users of the application in a database.			
<b>Data Validation:</b> The number of state and local public health professionals who use Epi-X to share intelligence regarding outbreaks and other emerging health events is captured in the Epi-X application. This number is tracked through the registration process of the application. There are automated system controls in place as well as manual procedures that are frequently conducted to validate that the information being collected is accurate. <u>Measure 2 - The number of members and users will be reviewed on a regular basis.</u>			
<b>Cross Reference:</b> <u>Measure 1 - HHS-2, 5, &gt;=4, 500-4; Measure 2 – HHS-2, PART, 500-4; Measure 3 - HHS-2, PART, 500-4</u>			

**Goal 2, Performance Measure 1:**

Epi-X, CDC's secure Web-based communications network for public health officials, links HHS and CDC with state terrorism surveillance and response programs, provides emergency alerts, and creates a forum to share important disease information nationwide. The usefulness of Epi-X has resulted in a substantial increase in the number of users well beyond the original target numbers.

In FY 2006, 4,220 health professionals used Epi-X. The FY 2006 target was exceeded by 1,020 as a result of CDC's vigorous recruitment effort.

**Goal 2, Performance Measure 2:**

BioSense program officials have determined that, by 2010, all levels of public health with jurisdiction over the top 50 U.S. metropolitan areas will use BioSense for biosurveillance and local health situational awareness as needed by accessing timely (<24 hours old) healthcare data from a statistically representative population. These ambitious steps require continuous program improvement, establishment of new partnerships and data sharing agreements, information technology improvements, and realization of efficiencies. They also reflect the commitment of program resources to the President's national priorities in coordination with the Office of the National Coordinator for Health Information Technology and the American Health Information Community (AHIC). The program's FY 2005 baseline and FY 2006 data for this output measure reflect its early and dramatic progress toward this goal.

BioSense acquired real-time clinical care data from over 350 healthcare sources in FY 2006. In addition to real-time sources, BioSense also receives data from 466 Department of Defense and 863 Veteran Administration healthcare facilities. In FY 2006, all data sources cover 27 BioWatch cities and 38 major metropolitan areas.

**Goal 2, Performance Measure 3:**

The time reductions stipulated by this performance measure will directly affect the ability of public health and law enforcement personnel to decrease the time to classify health issues as terrorism or naturally occurring, to decrease the time needed to detect aberrations. Indirectly, these time savings will decrease the time needed to communicate with the public about important health issues, and to identify and provide countermeasures.

PREPAREDNESS GOAL 3: DECREASE THE TIME NEEDED TO DETECT AND REPORT CHEMICAL, BIOLOGICAL, RADIOPHYSICAL AGENTS IN TISSUE, FOOD, OR ENVIRONMENTAL SAMPLES THAT CAUSE THREATS TO THE PUBLIC'S HEALTH.			
Measure	FY	Target	Result
1. 100% of states have level three chemical lab capacity, and have agreements with and access to (specimens arriving within 8 hours) a level-one chemical lab equipped to detect exposure to nerve agents, mycotoxins, and select industrial toxins. <sup>1</sup>	2008	100%	12/2008
	2007	100%	12/2007
	2006	100%	100% (Met)
	2005	25%	50% (Exceeded)
2. Maintain at 150 the number of toxic substances likely to be used in chemical terrorism that can be rapidly measured in blood and urine.	2008	150 substances	12/2008
	2007	150 substances	12/2007
	2006	150 substances	150 (Met)
	2005	150 substances	150 (Met)
	2004	150 substances	150 (Met)
3. Percentage of Laboratory Response Network (LRN) labs that pass proficiency testing for Category A and B threat agents.	2008	100%	12/2008
	2007	100%	12/2007
	2006	80%	83% (Exceeded)
	2005	75%	87% (Exceeded)
4. Number of Laboratory Response Network member laboratories able to use the current Laboratory Information Management System for electronic data exchange.	2008	30	12/2008
	2007	15	12/2007
	2006	Baseline	5
5. By 2010, the Laboratory Response Network Results Messenger will reduce the time needed from a triggering biosurveillance event (i.e., transmission of data regarding the identification of any Category A or B agent) to initiate event-specific standard operating procedures (e.g., aggregation of data at a national level) for all infectious, occupational or environmental (whether man-made or naturally occurring) threats of national importance. [O]	Targets Under Development		
6. By 2010, CDC's laboratory system will decrease the time from receipt of tissue, food and environmental samples to confirm and report chemical, biological and radiological agents to stakeholders. [O]	Targets Under Development		
<b>Data Source:</b> Measures 1, 2, 3 - The Laboratory Response Network (LRN) delivers accurate and timely identification of agents causing public health threats, including both naturally occurring disease and organisms that could be used in a biologic terrorism attack. <b>Measure 4</b> - In addition to specimen and results data, the Health Level 7 (HL7) message utilized for messaging LRN data to the CDC carries information regarding the specific data source. This information will allow us to differentiate between LRN Results Messenger and a local LIMS data. Further development is underway to allow easy reporting on various types of messages from the different sources, allowing us to quickly discern the number of messages related to various programs.			
<b>Data Validation:</b> <b>Measures 1,2,3</b> - The data collection and validation activities across the LRN significantly enhances the capacity of laboratories to rapidly detect and identify agents likely to be used in a terrorist attack and provide timely information to health professionals. <b>Measure 4</b> - Messages sent to the CDC from external sources must pass through the data broker before being parsed and sent to specific programs within the CDC. The Data and Message Brokering (DMB) team will perform edits to ensure that the message is formatted properly and that we have a Collaboration Protocol Agreement (CPA) with the originating entity. The DMB team will also perform some basic edits to ensure that the message contains all required fields and will also perform validation on the vocabulary included in the message to ensure that message utilizes standard vocabulary sets (LOINC, SNOMED, etc.). In addition, we will utilize PHINMS reporting to monitor activity, such as the volume of messages received over a predefined period, from the various partners. Additional validation includes periodic review by BPRP and NCPIR resources to ensure data quality and completeness. And finally, data that is shared with other programs such as BioSense and Biological Warning and Incident Characterization (BWIC) will undergo additional validation specific to that system.			

**Cross Reference:** Measures 1,3,4, 5, 6 - HHS-2, PART, 500-4; Measure 2 - HHS-2, 500-4

<sup>1</sup>Please note that the nomenclature has changed for chemical laboratories: level-three labs are now referred to as level-one labs and level-one labs are referred to as level-three labs.

**Goal 3, Performance Measure 1:**

Level-three laboratories, also called sentinel laboratories, rule out the presence of agents and refer samples to reference labs through the use of specified protocols. As a public health preparedness standard, each state should have the capacity to conduct, rule-out and transfer activities. CDC is training all 62 level-three public health chemical laboratories (i.e., chemical terrorism coordinators in these laboratories) in the proper collection and shipment of human samples following a chemical terrorism event. This training also includes four items: an overview of chemical agents; CDC's responsibilities in responding to chemical terrorism events; a discussion of federal regulations on diagnostic packaging procedures and evidentiary-control measures; and hands-on exercises involving the packaging and shipping of human samples. These public health chemical laboratories will then train internal partners (e.g., hospital laboratories, HAZMAT, doctors, office laboratories) in the proper collection and shipment of human samples after a chemical-terrorism event.

In FY 2006, significant progress was made on this measure as 100 percent of states have level-three lab capacity. Fifty percent of the states are within an eight hour driving distance to a level-one chemical laboratory due to CDC's efforts in increasing the number of level-one laboratories from five to ten in FY 2005.

CDC has discouraged the development of Memorandums of Understanding (MOUs) between states for specimen analysis, resulting in a small number of existing agreements. Developing MOUs between states may not be the most efficient use of time. At any given time, a level-one laboratory may be overwhelmed with specimens from their own population or those from another state, necessitating transfer of collected specimens to another level-one laboratory. Using this rationale, a given state would have to develop at least multiple MOUs (one with each level-one laboratory) to ensure their specimens would be analyzed by each facility. Using the Emergency Management Assistance Compact (EMAC) may be a better vehicle for level-three laboratories to make sure that specimens from their population are analyzed at a level-one laboratory.

**Goal 3, Performance Measure 2:**

The Rapid Toxic Screen (RTS) is a series of tests to identify various chemical agents in human blood or urine. In a chemical terrorism event, RTS will help determine what chemical agents were used, who has been exposed, and to what extent. In FY 2006, CDC maintained its capacity to analyze 150 toxic substances in the event of a chemical terrorism incident or other chemical emergency. Maintenance includes ensuring proper operation of analytic instrumentation, running particle samples during proficiency testing challenges and response exercises, and providing for a stockpile of supplies and analytic materials that would allow up to 5,000 samples to be analyzed in the case of a chemical event. CDC also is identifying back-up instrumentation that could be used if our primary response instruments are "down" during an event, and is ensuring that staff is cross-trained allowing for back-up analysts if a primary analyst is unavailable during an incident.

**Goal 3, Performance Measure 3:**

This measure determines the readiness posture of the Laboratory Response Network (LRN) for rapid detection of biological threat agents. Since laboratories infrequently encounter biological threat agents, the proficiency testing (PT) program provides familiarity in working with these agents, performing LRN assays using agent-specific testing algorithms, and using available electronic resources to report test results.

The PT program has been in place since the LRN was founded in FY 1999. At its onset, very few LRN member laboratories were able to rapidly and accurately identify biological threat agents and other agents of public health importance. Due to testing challenges and the need for increased training, the FY 2003 baseline passing rate was approximately 75 percent. By the end of FY 2005, the passing rate rose to 83 percent and at the close of FY 2006 the passing rate increased yet again to 87 percent.

A target of 90 percent for FY 2007 and FY 2008 is recommended, an ambitious, realistic, and achievable target. There are several reasons why a 100 percent passing rate is not feasible, including: the priority threat list evolves and thus tests for new agents are introduced to LRN laboratories; and new technologies and equipment become available that require additional training and experience to master new skills. Additionally, the LRN program office at CDC is working to increase the complexity of the PT program to include multiple agents in a single challenge, testing in various non-clinical samples (e.g., food, water, and environmental samples), and requirements to complete a full testing algorithm rather than solely focusing on rapid tests. The combination of new tests, new technologies, and the

increasing complexity of the PT program suggests a 100 percent passing rate is unachievable. However, laboratories that fail a proficiency test are required to go through remediation steps that may include consultation, successful completion of a follow-up proficiency test, and/or hands-on training.

**Goal 3, Performance Measure 4:**

The Laboratory Information Management System (LIMS) Integration Team is dedicated to producing tools to help laboratories enable standard electronic exchange of LRN data using their own laboratory information management systems (LIMS). Achieving the long-term objective for the LRN Results Messenger reflects the need to develop, maintain, and expand information technology solutions for rapid exchange of laboratory results to continuously reduce the amount of time required for critical results to be identified and reported. This requires continuous program improvement, establishment of new partnerships and data sharing agreements, information technology improvements, and realization of efficiencies. Currently, the best marker for network laboratories to indicate their readiness to improve timely reporting for action is their ability to utilize their current LIMS for electronic data exchange to 136 (the current number of member laboratories).

**Goal 3, Performance Measure 5:**

The time reductions stipulated by this performance measure will directly affect the ability of public health and law enforcement personnel to decrease the time to classify health issues as terrorism or naturally occurring, to decrease the time needed to detect aberrations. Indirectly, these time savings will decrease the time needed to communicate with the public about important health issues, and to identify and provide countermeasures.

**Goal 3, Performance Measure 6:**

The time reductions stipulated by this performance measure will directly affect the ability of public health and law enforcement personnel to identify events of national public health importance and indirectly will decrease the time needed to communicate with the public about important health issues, initiate investigations, and to identify and provide countermeasures.

PREPAREDNESS GOAL 4: IMPROVE THE TIMELINESS AND ACCURACY OF COMMUNICATIONS REGARDING THREATS TO THE PUBLIC'S HEALTH.			
Measure	FY	Target	Result
1. Increase the number of states and major metropolitan areas with access to Epi-X.	2008	250	12/2008
	2007	225	12/2007
	2006	150	154 (Exceeded)
	2005	125	137 (Exceeded)
	2004	100	100 (Met)
2. 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]	2008	100%	12/2008
	2007	100%	12/2007
	2006	100%	80% (Unmet)
	2005	100%	100% (Met)
<b>Data Source:</b> Epi-X Application, Laboratory Response Network Laboratories, Public Health Emergency Preparedness & Response Cooperative Agreement recipients.			
<b>Data Validation:</b> <u>Measure 1</u> - The Epi-X application is used to track how many reports are posted to the application annually, as well as how many states and major metropolitan areas have access to the application. This information is routinely analyzed through automated and manual procedures, to ensure it is accurate. <u>Measures 2</u> - While CDC is developing objective measures that define CDC-compliant, standards-based electronic disease surveillance systems, half of the grantee recipients report use of Internet browser-based data entry and receipt of electronic laboratory results (ELR). Additionally, all LRN Labs use established protocols for telephone reporting and have the ability to use a spreadsheet mechanism for reporting through the secure website.			
<b>Cross Reference:</b> ≈-4, 500-4; <u>Measure 1</u> - HHS-2, 5, ≈-4, 500-4; <u>Measure 2</u> - ≈-4, PART, 500-4			

**Goal 4, Performance Measure 1:**

Epi-X is CDC's secure web-based communications network for public health officials. In FY 2006, CDC increased the availability of Epi-X to 154 states and major metropolitan areas (all 50 states and 87 areas). At the end of FY 2006, 1,461 reports of disease outbreaks and other emerging health events had been posted on Epi-X. As more users participate in exchanging information via Epi-X, reports and use by public health authorities for the reporting of important public health events will increase.

**Goal 4, Performance Measure 2:**

Currently, all LRN labs can use established protocols for telephone reporting and, in addition, can use an interim spreadsheet mechanism for reporting through the secure website. The LRN was unable to meet its target of 100% for electronic reporting by the end of FY 2006. LRN laboratories faced a variety of challenges associated with the deployment of the software solution, Results Messenger version 2. Several issues delayed individual labs from installing the new software, including limited resources, labs lacking required hardware, and security issues associated with installing new hardware. Also, some labs have opted to forgo the installation of Results Messenger in favor of installing LIMS-compliant systems for reporting laboratory testing results to CDC.

**INVESTIGATION**

PREPAREDNESS GOAL 5: DECREASE THE TIME TO IDENTIFY CAUSES, RISK FACTORS, AND APPROPRIATE INTERVENTIONS FOR THOSE AFFECTED BY THREATS TO THE PUBLIC'S HEALTH.						
Measure	FY	Target	Result			
1. Increase the number of CDC professionals that are trained responders in the field.	2006	250	305 (Exceeded)			
	2005	150	97 (Unmet)			
2. Number of quarantine stations that are fully staffed with public health professionals who are preparedness to respond appropriately when needed.	2008	<b>Up to 25</b>	12/2008			
	2007	Up to 25	12/2007			
	2006	20	18 (Unmet)			
	2005	Baseline	10			
3. By 2010, the Quarantine Stations will reduce the time needed from a triggering biosurveillance event (notification of an international or interstate traveler who traveled while infectious with a quarantinable disease or other infectious disease of public health importance) to initiate event-specific standard operating procedures (e.g., isolation, quarantine, contact notification) for all infectious, occupational or environmental (whether man-made or naturally occurring) threats of national importance.	Targets Under Development					
4. By 2010, CDC's epidemiology system will reduce the time to initiate, coordinate and resolve investigations to identify causes, risk factors and recommended interventions. [O]	Targets Under Development					
<b>Data Source:</b> <u>Measure 1</u> - CDC's Field Services Office. <u>Measure 2</u> - The Quarantine Station Rating System developed by the Infrastructure workgroup in DGMQ.						
<b>Data Validation:</b> <u>Measure 1</u> – CDC's Field Services Office has developed training curriculum for all emergency responder staff. This curriculum was coordinated with CDC's Office of Workforce and Career Development, as well as CDC's Training and Education Goals and is continuously being validated and revised to meet the needs of CDC's emergency responder staff. The number of responders participating in these training courses is being tracked manually as well as through the web-based system that administers the online courses. Course evaluations are conducted after each training session (classroom and web-based) to determine the effectiveness of the course and identify areas for improvement. <u>Measure 2</u> – An Excel workbook is the tool that is to be utilized by each of the CDC Quarantine Stations to evaluate their infrastructure and operational readiness. It is comprised of eight sheets that correspond to the tabs at the bottom of the screen in Excel: Staffing; Office Space; Office Equipment; Office Furniture; HIR (Holding/Isolation Room); Office Supplies; Medical Equipment & Supplies; Transportation. Each of these sheets has lists of items and resources (including staff) that one will mark with an "X," "NA" or leave blank to indicate the current status of this resource at the Quarantine Station. The QS Rating System document explains how the system works, and describes the meaning of terms, such as C (critical), N (necessary) NR (needed but not rated), and the Holding/Isolation Room levels - (1,2,3,4).						
<b>Cross Reference:</b> <u>Measure 1</u> - 1, 500-4; <u>Measure 2</u> - 4 – HHS-2, PART, 500-4						

**Goal 5, Performance Measure 1:**

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 developed the training to prepare new emergency response field staff for responsibilities in the field. Discipline specific competency-based guidelines have been established. A two-week course basic training curriculum ("boot camp") was developed for all emergency response staff. The training plan and curriculum were coordinated with CDC training goals and were integrated into CDC's Office of Workforce and Career Development.

In FY 2006, two course offerings were held in Anniston, AL at the FEMA Noble Trainings Center. Now that the data for FY 2006 have been reported, the measure is retired and will not be reflected in future performance detail.

**Goal 5, Performance Measure 2:**

Rebuilding the Quarantine System is necessary to protect the United States from international biological threats, both natural and intentional. Quarantine Station expansion and enhancement will improve the systematic collection, analysis, interpretation, and dissemination of data related to public health events at U.S. ports of entry. An expanded and enhanced quarantine system includes not only increasing CDC's physical presence at U.S. ports of entry, but also staffing each station with a multidisciplinary team of quarantine medical officers, public health advisors, epidemiologists, and information technicians, enhancing the stations' links to a global network for international traveler disease surveillance, increasing preparedness and response at ports of entry, and expanding collaboration and partnership activities with state and local agencies.

**Goal 5, Performance Measure 3:**

The time reductions stipulated by this performance measure will directly affect the ability of public health and law enforcement personnel to decrease the time to classify health issues as terrorism or naturally occurring, to decrease the time needed to detect aberrations. Indirectly, these time savings will decrease the time needed to communicate with the public about important health issues, and to identify and provide countermeasures.

**Goal 5, Performance Measure 4:**

The time reductions stipulated by this performance measure will directly affect the ability of public health and law enforcement personnel to implement prevention interventions, decrease the time to classify health issues as terrorism or naturally occurring, and decrease the time to identify risk factors and causes of urgent public health events. These time savings will decrease the time needed to communicate with the public about important health issues, and to identify and provide countermeasures.

**CONTROL**

GOAL 6: DECREASE THE TIME NEEDED TO PROVIDE COUNTERMEASURES AND HEALTH GUIDANCE TO THOSE AFFECTED BY THREATS TO THE PUBLIC'S HEALTH.			
Measure	FY	Target	Result
1. Expand and enhance the Health Alert Network's (HAN) ability to rapidly provide access to public health guidelines, best practices, and information on the effectiveness of public health interventions.	2008	a) 80% of state health departments acknowledge receipt of health alert messages within 30 minutes of delivery on a 24/7 basis  c) 85% of state grantees will have a protocol for testing and documenting send/receive capabilities	12/2008
	2007	a) 75% of state health departments acknowledge receipt of health alert messages within 30 minutes of delivery on a 24/7 basis  c) 80% of state grantees will have a protocol for testing and documenting send/receive capabilities	12/2007
	2006	a) 70% of state health departments acknowledge receipt of health alert messages within 30 minutes of delivery on a 24/7 basis.  b) N/A  c) 75% of state grantees will have a protocol for testing and documenting send/receive capabilities  d) N/A	a) 58% of Cooperative Agreement recipients acknowledge receipt of health alert messages within 30 minutes of delivery on a 24/7 basis (Unmet)  b) N/A  c) 12/2007  d) N/A
	2005	a) 65% of state and 35% of local health departments will acknowledge receipt of health alert messages within 30 minutes of delivery on a 24/7 basis  b) 65% of state grantees will have communication established with identified, key stakeholders  c) 60% of state grantees will have a protocol for testing and documenting send/receive capabilities  d) Establish interoperable wireless redundant communication systems in 55% of state health departments	a) 57% of Cooperative Agreement recipients acknowledge receipt of health alert messages within 30 minutes of delivery on a 24/7 basis (Unmet)  b) 97% (Exceeded)  c) 60% (Met)  d) 98% (Exceeded)
	2004	a) 60% of states and 25% of local health departments will acknowledge receipt of health alert messages within 30 minutes of delivery on a 24/7 basis  b) 50% of state grantees will have communication established with identified, key stakeholders  c) 50% of state grantees will have a protocol for testing and documenting send/receive capabilities  d) Establish interoperable wireless redundant communication systems in 40% of state health departments	a – d) Unmet
2. 100% of state public health agencies are prepared to use materiel contained in the SNS as demonstrated by evaluation of standard functions as determined by CDC. [O]	2008	<b>90% prepared</b>	12/2008
	2007	90% prepared	12/2007
	2006	80% prepared	70% (Unmet)
	2005	70% prepared	76% (Exceeded)
	2004	60% prepared	72% (Exceeded)

<b>GOAL 6: DECREASE THE TIME NEEDED TO PROVIDE COUNTERMEASURES AND HEALTH GUIDANCE TO THOSE AFFECTED BY THREATS TO THE PUBLIC'S HEALTH.</b>						
<b>Measure</b>	<b>FY</b>	<b>Target</b>	<b>Result</b>			
3. Number of treatments/prophylaxis for the appropriate response to known terrorist threats or public health emergencies for chemical, biological, radiological and nuclear threats in millions. [O]	2008	2.3, 60, 0.17	12/2008			
	2003	Baseline	.2, 1.4, .4			
4. The number of successful annual exercises that test response to multiple events with a 12-hour response time. [O]	2008	1	12/2008			
	2007	1	12/2007			
	2006	1	1 (Met)			
	2005	Baseline	1			
5. Number of trained and ready Technical Advisory Response Units (TARU) for response to multiple events.	2008	9	12/2008			
	2007	7	12/2007			
	2006	6	6 (Met)			
	2005	Baseline	5			
6. Percentage of inventory discrepancies that are reduced by using quality inventory management systems. [O]	2008	<5%	12/2008			
	2007	<5%	12/2007			
	2006	<5%	0.33% (Exceeded)			
	2005	Establish Baseline	6 % (Met)			
7. By 2010, CDC's response operations system will decrease the time from event to actions that will minimize morbidity and mortality. [O]	Targets Under Development					
<b>Data Source:</b> <u>Measure 1</u> - HAN, CDC's Division of the Strategic National Stockpile (SNS); <u>Measure 2</u> - Completed SNS Assessment Tools, based on criteria outlined in A Guide for Preparedness, V 10.00.; <u>Measures 3, 4, 5, 6</u> – DSNS.						
<b>Data Validation:</b> <u>Measure 1</u> – At CDC, HAN is maintained by the National Center for Public Health Informatics (NCPHI). The data that passes through and is captured in HAN is frequently validated by NCPHI staff. <u>Measure 2</u> – The SNS program maintains a staff Program Services Consultants who provide ongoing technical advice and training assistance to Public health Emergency Preparedness & Response grantees. The consultants also assess the grantee's level of preparedness to receive, distribute and dispense SNS assets. These services improve the grantee's ability to receive, stage, store and distribute the SNS materiel. <u>Measures 3, 4, 5, 6</u> – DSNS maintains internal tracking systems to monitor its ability to deliver critical medical assets in a national emergency. A new Stockpile Resource Planning (SRP) database and inventory system is used to track and validate stockpiled material.						
<b>Cross Reference:</b> <u>Measure 1</u> - 4, 5, HHS-2, PART, 500-4; <u>Measure 2</u> - HHS-2, 4, 5, PART, PAR, 500-4; <u>Measure 3, 4, 5, 6, 7</u> – HHS-2, PART, 500-4						

#### **Goal 6, Performance Measure 1:**

Currently, three basic building blocks for routine and emergency information dissemination are being completed nationwide by HAN:

- Continuous high-speed Internet connectivity to support rapid information access.
- Broadcast capacity to support emergency communication.
- Establishment of redundant communications.

To obtain the status of performance for this measure, CDC's National Center for Public Health Informatics sent a test message to the 62 Bioterrorism Cooperative Agreement grantees. Of those, 58 percent responded within 30 minutes. Overall, 85 percent responded. CDC also used survey results of the 50 states, seven pacific jurisdictions, and four cities/districts for measuring communication established with identified key stakeholders and establishment of interoperable wireless redundant communication systems.

Plans for coming years include continued technical assistance and network testing to ensure timely message translation, dissemination, local response, and feedback. Note that targets b) and d) will be retired after data are reported for FY 2005.

**Goal 6, Performance Measure 2:**

CDC describes 12 functions of SNS Preparedness required for the effective management and use of deployed SNS materiel. Based on these functions, grantees are required to develop SNS Preparedness Plans detailing the performance of these functions during an emergency. In an effort to enhance grantee SNS preparedness planning efforts, CDC maintains a staff of program service consultants who provide ongoing technical advice and training assistance to grantees. These consultants also assess the grantees' level of preparedness to receive, distribute and dispense SNS assets. This measure is a CDC challenge. Many jurisdictions lack proper facilities to receive the 50-ton package of SNS material. However, CDC provides technical assistance, education and training to improve the ability of states to receive stage, store and distribute the SNS material. In FY 2006, CDC is at 70 percent, not meeting its target of 80 percent.

**Goal 6, Performance Measures 3:**

As a result of the PART process, CDC developed this long-term performance measure. CDC will grow and maintain treatment/prophylaxis capability for chemical, biological, radiological/nuclear threats. CDC will report on the measure in FY 2008.

**Goal 6, Performance Measures 4 - 5:**

As a result of the PART process, CDC developed new performance measures. In FY 2006, CDC met its goal of conducting one annual exercise that tested response to multiple events within a 12-hour response time. CDC also met its goal of six trained and ready Technical Advisory Response Units (TARU) for response to multiple events.

**Goal 6, Performance Measure 6:**

As a result of the PART process, CDC developed this performance measure to track inventory discrepancies. In FY 2006, inventory discrepancies were reduced to 0.33 percent, exceeding the target of less than 5 percent.

**Goal 6, Performance Measure 7:**

The time reductions stipulated by this performance measure will directly affect the ability of public health and law enforcement personnel to identify events of national public health importance, initiate investigations, determine causes and risk factors, identify and implement effective countermeasures and provide timely and accurate communications with the public.

**RECOVER**

Preparedness Goals seven (Decrease the time needed to restore health services and environmental safety to pre-event levels) and eight (Improve the long-term follow-up provided to those affected by threats to the public's health) do not currently have supporting performance measures.

**IMPROVE**

PREPAREDNESS GOAL 9: DECREASE THE TIME NEEDED TO IMPLEMENT RECOMMENDATION FROM AFTER ACTION REPORTS FOLLOWING THREATS TO THE PUBLIC'S HEALTH.			
Measure	FY	Target	Result
1. 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.	2008	100%	12/2008
	2007	100%	12/2007
	2006	100%	94% (Unmet)
	2005	25%	94% of state public health agencies have developed plans for at least one priority agent (Met)
2. Increase the percentage of the TPER allocation for which budget execution matches strategic funding priorities.	Targets Under Development		

**PREPAREDNESS GOAL 9: DECREASE THE TIME NEEDED TO IMPLEMENT RECOMMENDATION FROM AFTER ACTION REPORTS FOLLOWING THREATS TO THE PUBLIC'S HEALTH.**

<b>Measure</b>	<b>FY</b>	<b>Target</b>	<b>Result</b>
3. Improve the on-time achievement of individual project milestones for Epidemiology, Laboratories and Emergency Response.	2008	93%	12/2008
	2007	90%	12/2007
	2006	Baseline	87%
4. Achieve progressive improvements in the quality of projects submitted for TPER Upgrading CDC Capacity funding consideration.	2008	78%	12/2007
	2007	Baseline	74%
<b>Data Source:</b> Self-reported data as part of required progress reports.			
<b>Data Validation:</b> See Efficiency Measure Data Validation.			
<b>Cross Reference:</b> Measure 1 - HHS-2, PART, PAR, 500-4; Measures 2 – 4 - PART			

**Goal 9, Performance Measure 1:**

In order for state and local public health agencies to test their capabilities for responding to bioterrorism, chemical exposures, and other public health emergencies, CDC recommends that response plans be tested regularly by staff participation in exercises and simulation drills. Lessons learned from both responses to real events and annual exercises can help identify gaps in preparedness planning and should result in improved public health responses.

In FY 2006, 94 percent (47 of 50) of State health agencies exercised their plans for at least one priority agent. In future years, grantees will need to implement corrective actions within 90 days of identifying a deficiency through a drill, exercise, or real event. The FY 2006 - 2008 targets expect that 100 percent of grantees will meet requirements in these areas. In FY 2006, this measure was not met. However, future exercises, focusing on non-pharmacologic interventions and mass prophylaxis, will be closely monitored to ensure achievement of the 100 percent goal.

**Goal 9, Performance Measure 2:**

This measure reflects the need to ensure that budget execution matches strategic funding priorities. CDC is developing a decision-support process for linking budget formulation to the priorities identified in the preparedness goal action plan. This decision-support process will allow consideration of new initiatives, expansion or enhancement to existing projects, or the elimination of completed or out-dated projects.

**Goal 9, Performance Measure 3:**

All individual projects funded to upgrade CDC capacity must improve performance in order to achieve the long-term measures. Individual project performance is monitored continuously and can be summarized as the average time-appropriate achievement of milestones in the core functional areas.

**Goal 9, Performance Measure 4:**

The spending plan process maximizes efficiency by centralizing the project submission and review process, thereby allowing for the early identification of duplicative efforts. Project submissions include detailed workplans and timelines, and must include responses to standardized evaluation questions that are used to rate and select projects for funding. This process allows for the selection of projects that are most likely to achieve the objectives of upgrading some part of CDC's preparedness capacity, are not duplicative of each other, are well-specified and likely to succeed.

## **CHANGES AND IMPROVEMENTS OVER PREVIOUS YEARS**

From FY 2003 to 2008, CDC/ATSDR reduced the total number of measures included in its performance plan by eight percent. The proportion of outcome measures to the total number of measures increased from 44 percent in FY 2003 to 48 percent in FY 2008. The FY 2008 Congressional Justification includes several specific changes from the FY 2007 Congressional Justification.

### **PART MEASURES**

As a result of OMB's 2006 Program Assessment Rating Tool (PART) process, CDC added performance measures to the FY 2008 annual performance plans, many of which were enhancements upon previous GPRA measures.

In 2006, CDC had five programs reviewed through PART, resulting in a total of 43 new performance measures (four efficiency measures, 33 outcome measures and six output measures) were added to CDC's performance plan. CDC's 2006 PART programs include Injury Prevention and Control, Chronic Disease Prevention, Birth Defects and Developmental Disabilities, BioSurveillance and Upgrading CDC Capacity. To review the new measures, refer to the Detail of Performance Analysis sections.

### **PREPAREDNESS FRAMEWORK**

In FY 2004, CDC developed a new framework to execute the agency's overarching preparedness goals. Following the establishment of this framework, CDC aligned its existing Terrorism performance measures to the appropriate preparedness goals within the new framework. For those goals for which current performance measures do not exist, CDC is leading an effort in coordination with OMB and HHS to develop new outcome-oriented measures. The performance information found in the Detail of Performance Analysis section reflects CDC's new framework for its preparedness goals.

### **EFFICIENCY MEASURES**

Consistent with the PMA Standards for Success for Budget and Performance Integration, CDC "has at least one efficiency measure for all PART'ed programs." To meet this requirement, CDC developed and OMB approved a new efficiency measure for the Immunization, Domestic HIV/AIDS prevention, STD/TB and State and Local Preparedness programs. The Breast & Cervical Cancer and Diabetes' programs had efficiency measures which were approved by OMB as well. However, these measures were subsumed into the new National Center for Chronic Disease Prevention and Health Promotion measure developed through PART. CDC had five programs reviewed through PART for the 2006 cycle, resulting in four new efficiency measures added to CDC's performance plan (Biosurveillance and Upgrading CDC Capacity programs have the same efficiency measure).

### **COORDINATING CENTER FOR INFECTIOUS DISEASES**

The Coordinating Center for Infectious Diseases has been reorganized into four Centers and Budget Activities: Immunization and Respiratory Diseases; HIV/AIDS, Viral Hepatitis, STD and TB Prevention; Zoonotic, Vector-Borne, and Enteric Diseases; and Preparedness, Detection and Control of Infectious Diseases. While the goals and measures remain the same, several have been moved based on the new budget structure.

PERFORMANCE DETAIL  
CHANGES AND IMPROVEMENTS OVER PREVIOUS YEARS

**CHANGE TABLE**

Program Activity	Goal	Previous Measure	Change and Explanation
Domestic HIV/AIDS Prevention	Efficiency Measure	Increase the number of states using confidential name-based HIV reporting systems.	<i>Approved by OMB May, 2006 - Improve the accuracy of the portrayal of the U.S. HIV epidemic in national reports by increasing the number of states using confidential name-based HIV reporting methods with level funding, thereby enabling CDC to report standardized HIV data from a larger number of jurisdictions.</i>
STD/TB Prevention	Efficiency Measure	Reduce division-level printing costs by offering updated tuberculosis (TB) educational and training materials on CD ROM rather than printed materials.	<i>OMB Approved May, 2006 - Reduce the amount of time it takes to award grantees' unobligated funds by meeting the Procurement and Grant Office's (PGO) key performance targets without increased funding.</i>
Immunization	Efficiency Measure	Establish a target range for VFC and Section 317 funds requested by grantees for assessing vaccination coverage levels and providing feedback (AFIX) in healthcare provider office and clinic settings, and continue to monitor progress toward achieving the AFIX cost range.	<i>OMB Approved May, 2006 - Make vaccine distribution more efficient and improve availability of vaccine inventory by reducing the number of vaccine inventory depots in the U.S.</i>
Breast and Cervical Cancer	Efficiency Measure	<i>Approved by OMB May, 2006 – Improve the volume and quality of screening/diagnostic services by increasing the percent of appropriated funds awarded above baseline to the most efficient and effective grantees.</i>	This measure is no longer displayed in the budget submission due to the development of a Center-wide PART efficiency measure.
Diabetes	Efficiency Measure	<i>Approved by OMB May, 2006 Improve technical assistance to grantees by increasing the proportion of Program Development Branch staff time dedicated to providing technical assistance to grantees instead of performing administrative management duties.</i>	This measure is no longer displayed in the budget submission due to the development of a Center-wide PART efficiency measure.

**PERFORMANCE DETAIL**  
**CHANGES AND IMPROVEMENTS OVER PREVIOUS YEARS**

Program Activity	Goal	Previous Measure	Change and Explanation
<b>State and Local Preparedness</b>	Efficiency Measure	N/A	Decrease the amount of time it takes the Division of State and Local Readiness (DSLR) Project Development Officers to conduct technical reviews of work plans and budgets for all 62 grantees by providing appropriate tools and functionality in the DSLR Management Information System (MIS)
<b>Chronic Disease Prevention and Health Promotion</b>	Efficiency Measure	N/A	<i>New PART Measure:</i> Number of financial actions (such as project carryover funds requests from grantees and grantee project re-budgetings) that delay the implementation of grantee and partners' activities.
<b>Birth Defects and Developmental Disabilities</b>	Efficiency Measure	N/A	<i>New PART Measure:</i> Increase the percent of competitive (new) cooperative agreements/grants that are processed in less than or equal to 176 days (excluding extramural research).
<b>Injury Prevention and Control</b>	Efficiency Measure	N/A	<i>New PART Measure:</i> Reduce the amount of time to submit funding packages for non-research funding opportunities to CDC's Procurement and Grants Office.
<b>Biosurveillance and Upgrading CDC Capacity</b>	Efficiency Measure	N/A	<i>New PART Measure:</i> Decrease annual costs for personnel and materials development with the development and continuous improvement to the budget and performance integration information system tools.
<b>Health Marketing</b>	CDC will develop and implement training to provide for an effective, prepared, and sustainable health workforce able to meet emerging health challenges.	Refer to change section.	<i>New overarching goal has a broader scope to better reflect the program's mission:</i> CDC will maintain and improve its website and electronic communications to provide science-based health information to health care professionals, CDC partners and the American public.
	CDC will maintain and improve its website and electronic communications to provide science-based health information to health care professionals, CDC partners and the American public.	Increase the number of interventions adopted by state health officers that were recommended by the <i>Community Guide</i> .	<i>New measure has a broader scope to better reflect the program's mission:</i> Increase access and utilization of CDC.gov by public, partners, and other health care professionals.

**PERFORMANCE DETAIL**  
**CHANGES AND IMPROVEMENTS OVER PREVIOUS YEARS**

Program Activity	Goal	Previous Measure	Change and Explanation
	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.	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 (retiring after FY 2006). <i>Targets based on the number of images in the Public Health Image Library.</i>	<i>Replacing retired measure with one which better reflects the intent of the overarching goal:</i> Increase the usage of CDC's online public health emergency alert systems, training materials, and other electronic resources/tools designed to provide information, educational materials, and real-time alerts as measured by the number of subscribers to Epi-X, HAN and national public health radio networks.
<b>Environmental Health</b>	Determine human health effects associated with environmental exposures	Assess exposure of the U.S. population to environmental chemicals, including nutritional indicators.	New 2005 PART measure – reworded: Number of environmental chemicals, including nutritional indicators, that are assessed for exposure of the U.S. population.
	Prevent or Reduce Illnesses, Injury, and Death Related to Environmental Risk Factors.	Reduce asthma hospitalizations in states funded by CDC to implement comprehensive asthma control programs.	New 2005 PART measure – reworded: Percentage reduction in asthma hospitalizations in states funded for partial and full implementation per 100,000 people.
		Reduce the number of children with elevated BLLs.	New 2005 PART measure – reworded: Number of children under age 6 with elevated blood lead levels.
		Increase the capacity of state, local and tribal agencies for which CDC provides assistance to prevent the spread of outbreaks from food- and water-borne illness.	New 2005 PART measure – reworded: Percentage increase in the capacity of state health departments to anticipate and prevent the spread of illness/disease outbreaks from food- and water-borne illness.
<b>Global Health: Global Immunizations</b>	Work with global partners to reduce the cumulative global measles-related mortality by 90% compared with 2000 estimates (baseline 777,000 deaths) and to maintain elimination of endemic measles transmission in all 47 countries of the Americas.	By 2015, reduce by 90 percent the cumulative global measles-related mortality compared with 2000 estimates (Baseline: 777,000 deaths).	New 2005 PART measure – reworded: Number of global measles-related deaths.
		Eliminate measles transmission in all 47 countries of the Americas.	New 2005 PART measure – reworded: Number of non-import measles cases in all 47 countries of the Americas as a measure of maintaining elimination of endemic measles transmission.

PERFORMANCE DETAIL  
CHANGES AND IMPROVEMENTS OVER PREVIOUS YEARS

Program Activity	Goal	Previous Measure	Change and Explanation
Office of Minority Health	N/A	N/A	<p><i>New Goal:</i> Support and strengthen capacity development strategies of existing National and Regional Minority Organizations.</p>
	Support and strengthen capacity development strategies of existing National and Regional Minority Organizations.	N/A	<p><i>New Measure:</i> Increase the number of national and regional public health collaborations with public health agencies/organizations serving minority communities via the delivery of culturally-proficient and linguistically-appropriate public health services and by developing, promoting, and marketing health promotion and professional training and educational programs and materials.</p>
		N/A	<p><i>New Measure:</i> Identify program and organizational infrastructure needs (i.e., policy analysis, program assessment and development, and evaluation) of public health agencies/organizations serving minority communities and provide technical assistance to improve the health status and access to programs for racial and ethnic minority populations.</p>

# **SUPPLEMENTAL MATERIAL**

**STATE AND FORMULA GRANT PROGRAMS**

**PREVENTIVE HEALTH AND HEALTH SERVICES BLOCK GRANT TABLE**

<b>FY 2008 BUDGET SUBMISSION</b> <b>CENTERS FOR DISEASE CONTROL AND PREVENTION</b> <b>FY 2008 DISCRETIONARY STATE/FORMULA GRANTS</b>				
<b>CFDA NUMBER/PROGRAM NAME: PREVENTIVE HEALTH AND HEALTH SERVICES BLOCK GRANT TABLE</b>				
<b>State/Territory</b>	<b>FY 2006 Actual</b>	<b>FY 2007 CR</b>	<b>FY 2008 Budget</b>	<b>FY 2008 +/- FY 2007</b>
Alabama	\$1,561,826	\$1,561,826	\$0	(\$1,561,826)
Alaska	\$337,787	\$337,787	\$0	(\$337,787)
Arizona	\$1,179,532	\$1,179,532	\$0	(\$1,179,532)
Arkansas	\$879,295	\$879,295	\$0	(\$879,295)
California	\$6,820,205	\$6,820,205	\$0	(\$6,820,205)
Colorado	\$1,220,128	\$1,220,128	\$0	(\$1,220,128)
Connecticut	\$1,422,390	\$1,422,390	\$0	(\$1,422,390)
Delaware	\$184,263	\$184,263	\$0	(\$184,263)
District of Columbia	\$751,917	\$751,917	\$0	(\$751,917)
Florida	\$2,978,945	\$2,978,945	\$0	(\$2,978,945)
Georgia	\$3,025,723	\$3,025,723	\$0	(\$3,025,723)
Hawaii	\$762,579	\$762,579	\$0	(\$762,579)
Idaho	\$365,501	\$365,501	\$0	(\$365,501)
Illinois	\$2,350,067	\$2,350,067	\$0	(\$2,350,067)
Indiana	\$1,659,205	\$1,659,205	\$0	(\$1,659,205)
Iowa	\$1,079,949	\$1,079,949	\$0	(\$1,079,949)
Kansas	\$895,862	\$895,862	\$0	(\$895,862)
Kentucky	\$1,320,063	\$1,320,063	\$0	(\$1,320,063)
Louisiana	\$2,838,802	\$2,838,802	\$0	(\$2,838,802)
Maine	\$872,017	\$872,017	\$0	(\$872,017)
Maryland	\$1,851,803	\$1,851,803	\$0	(\$1,851,803)
Massachusetts	\$2,663,359	\$2,663,359	\$0	(\$2,663,359)
Michigan	\$3,878,924	\$3,878,924	\$0	(\$3,878,924)
Minnesota	\$2,474,018	\$2,474,018	\$0	(\$2,474,018)
Mississippi	\$1,423,855	\$1,423,855	\$0	(\$1,423,855)
Missouri	\$2,441,987	\$2,441,987	\$0	(\$2,441,987)
Montana	\$645,459	\$645,459	\$0	(\$645,459)
Nebraska	\$1,592,139	\$1,592,139	\$0	(\$1,592,139)
Nevada	\$387,170	\$387,170	\$0	(\$387,170)
New Hampshire	\$1,388,849	\$1,388,849	\$0	(\$1,388,849)
New Jersey	\$2,843,269	\$2,843,269	\$0	(\$2,843,269)
New Mexico	\$1,368,111	\$1,368,111	\$0	(\$1,368,111)
New York	\$6,770,526	\$6,770,526	\$0	(\$6,770,526)
North Carolina	\$2,694,665	\$2,694,665	\$0	(\$2,694,665)
North Dakota	\$250,692	\$250,692	\$0	(\$250,692)

SUPPLEMENTAL MATERIAL  
STATE AND FORMULA GRANT PROGRAMS

<b>FY 2008 BUDGET SUBMISSION</b> <b>CENTERS FOR DISEASE CONTROL AND PREVENTION</b> <b>FY 2008 DISCRETIONARY STATE/FORMULA GRANTS</b>				
<b>CFDA NUMBER/PROGRAM NAME: PREVENTIVE HEALTH AND HEALTH SERVICES BLOCK GRANT TABLE</b>				
<b>State/Territory</b>	<b>FY 2006 Actual</b>	<b>FY 2007 CR</b>	<b>FY 2008 Budget</b>	<b>FY 2008 +/- FY 2007</b>
Ohio	\$4,446,617	\$4,446,617	\$0	(\$4,446,617)
Oklahoma	\$927,095	\$927,095	\$0	(\$927,095)
Oregon	\$716,429	\$716,429	\$0	(\$716,429)
Pennsylvania	\$4,685,903	\$4,685,903	\$0	(\$4,685,903)
Rhode Island	\$465,364	\$465,364	\$0	(\$465,364)
South Carolina	\$1,210,792	\$1,210,792	\$0	(\$1,210,792)
South Dakota	\$229,317	\$229,317	\$0	(\$229,317)
Tennessee	\$1,602,849	\$1,602,849	\$0	(\$1,602,849)
Texas	\$4,043,849	\$4,043,849	\$0	(\$4,043,849)
Utah	\$942,017	\$942,017	\$0	(\$942,017)
Vermont	\$267,593	\$267,593	\$0	(\$267,593)
Virginia	\$2,009,185	\$2,009,185	\$0	(\$2,009,185)
Washington	\$1,007,626	\$1,007,626	\$0	(\$1,007,626)
West Virginia	\$878,445	\$878,445	\$0	(\$878,445)
Wisconsin	\$1,923,229	1,923,229	\$0	(\$1,923,229)
Wyoming	\$222,559	222,559	\$0	(\$222,559)
<b>Subtotal</b>	<b>\$90,759,751</b>	<b>\$90,759,751</b>	<b>\$0</b>	<b>(\$90,759,751)</b>
Indian Tribes	\$57,512	\$57,512	\$0	(\$57,512)
Migrant Program	\$0	\$0	\$0	\$0
American Samoa	\$51,808	\$51,808	\$0	(\$51,808)
Guam	\$213,785	\$213,785	\$0	(\$213,785)
Marshall Islands	\$0	\$25,838	\$0	(\$25,838)
Micronesia	\$62,938	\$62,938	\$0	(\$62,938)
Northern Mariana Islands	\$39,505	\$39,505	\$0	(\$39,505)
Palau	\$20,567	\$20,567	\$0	(\$20,567)
Puerto Rico	\$1,536,725	\$1,536,725	\$0	(\$1,536,725)
Virgin Islands	\$169,056	\$169,056	\$0	(\$169,056)
<b>Subtotal</b>	<b>\$2,151,896</b>	<b>\$2,151,896</b>	<b>\$0</b>	<b>(\$2,151,896)</b>
<b>Total States/Territories</b>	<b>\$92,911,647</b>	<b>\$92,937,485</b>	<b>\$0</b>	<b>(\$92,937,485)</b>
Assessment Initiative (CCHIS)	\$2,388,609	\$2,388,609	\$0	(\$2,388,609)
Program Management, Accountability, and Evaluation	\$3,631,744	\$3,673,906	\$0	(\$3,673,906)
State Penalties	-	-	-	-
Contingency Fund	-	-	-	-
Other Adjustments (specify)	-	-	-	-
<b>Subtotal Adjustments</b>	<b>\$6,020,353</b>	<b>\$6,062,515</b>	<b>\$0</b>	<b>(\$6,062,515)</b>
<b>TOTAL</b>	<b>\$98,932,000</b>	<b>\$99,000,000</b>	<b>\$0</b>	<b>(\$99,000,000)</b>

**FY 2008 CONGRESSIONAL JUSTIFICATION**  
**SAFER·HEALTHIER·PEOPLE™**

SUPPLEMENTAL MATERIAL  
STATE AND FORMULA GRANT PROGRAMS

**VACCINES FOR CHILDREN STATE-BY-STATE TABLE**

<b>FY 2008 BUDGET SUBMISSION CENTERS FOR DISEASE CONTROL AND PREVENTION FY 2008 MANDATORY STATE/FORMULA GRANTS VACCINES FOR CHILDREN PROGRAM</b>				
State/Territory/Grantee	FY 2006 Actual	FY 2007 CR	FY 2008 Budget	FY 2008 +/- FY 2007
Alabama	\$31,993,366	\$47,055,869	\$45,956,000	(\$1,099,869)
Alaska	\$6,772,224	\$9,880,470	\$9,607,872	(\$272,598)
Arizona	\$53,299,116	\$78,403,626	\$76,576,890	(\$1,826,736)
Arkansas	\$18,806,274	\$27,659,986	\$27,013,316	(\$646,670)
California	\$219,195,776	\$322,715,141	\$315,339,408	(\$7,375,732)
Colorado	\$21,871,530	\$32,103,931	\$31,319,890	(\$784,041)
Connecticut	\$13,452,844	\$19,629,743	\$19,089,450	(\$540,293)
Delaware	\$5,762,561	\$8,404,369	\$8,170,906	(\$233,463)
District of Columbia	\$5,787,923	\$8,359,219	\$8,083,944	(\$275,274)
Florida	\$94,187,718	\$138,529,911	\$135,291,198	(\$3,238,714)
Georgia	\$73,580,732	\$108,296,746	\$105,803,999	(\$2,492,746)
Hawaii	\$5,453,732	\$7,775,881	\$7,466,510	(\$309,370)
Idaho	\$9,018,211	\$13,239,222	\$12,916,894	(\$322,327)
Illinois	\$55,522,373	\$81,683,282	\$79,784,925	(\$1,898,358)
Indiana	\$30,728,224	\$45,082,758	\$43,970,603	(\$1,112,154)
Iowa	\$12,748,657	\$18,673,988	\$18,197,608	(\$476,380)
Kansas	\$13,819,693	\$20,253,529	\$19,742,443	(\$511,085)
Kentucky	\$18,245,259	\$26,832,701	\$26,204,253	(\$628,448)
Louisiana	\$32,525,001	\$47,802,240	\$46,666,439	(\$1,135,801)
Maine	\$6,929,889	\$10,039,132	\$9,724,753	(\$314,379)
Maryland	\$25,739,421	\$37,813,938	\$36,907,407	(\$906,531)
Massachusetts	\$29,716,448	\$43,636,768	\$42,580,316	(\$1,056,453)
Michigan	\$55,425,441	\$81,474,972	\$79,547,304	(\$1,927,668)
Minnesota	\$18,484,952	\$27,134,332	\$26,472,366	(\$661,966)
Mississippi	\$21,069,213	\$31,005,300	\$30,289,267	(\$716,034)
Missouri	\$27,273,775	\$40,094,889	\$39,147,637	(\$947,252)
Montana	\$4,910,250	\$7,182,682	\$6,994,355	(\$188,327)
Nebraska	\$9,270,267	\$13,619,899	\$13,293,848	(\$326,051)
Nevada	\$18,088,069	\$26,530,825	\$25,872,687	(\$658,138)
New Hampshire	\$5,983,713	\$8,729,932	\$8,489,012	(\$240,920)
New Jersey	\$41,665,607	\$61,228,456	\$59,769,583	(\$1,458,872)
New Mexico	\$19,716,377	\$28,934,482	\$28,224,706	(\$709,777)
New York	\$43,876,350	\$64,123,948	\$62,412,278	(\$1,711,669)
North Carolina	\$40,167,469	\$58,996,059	\$57,574,323	(\$1,421,736)
North Dakota	\$3,134,198	\$4,578,429	\$4,455,115	(\$123,314)

SUPPLEMENTAL MATERIAL  
STATE AND FORMULA GRANT PROGRAMS

<b>FY 2008 BUDGET SUBMISSION</b> <b>CENTERS FOR DISEASE CONTROL AND PREVENTION</b> <b>FY 2008 MANDATORY STATE/FORMULA GRANTS</b> <b>VACCINES FOR CHILDREN PROGRAM</b>				
State/Territory/Grantee	FY 2006 Actual	FY 2007 CR	FY 2008 Budget	FY 2008 +/- FY 2007
Ohio	\$42,725,845	\$62,898,403	\$61,457,972	(\$1,440,432)
Oklahoma	\$35,207,845	\$51,711,790	\$50,465,696	(\$1,246,094)
Oregon	\$22,811,160	\$33,461,917	\$32,633,645	(\$828,272)
Pennsylvania	\$37,936,573	\$55,486,706	\$54,028,383	(\$1,458,323)
Rhode Island	\$7,084,568	\$10,350,476	\$10,072,409	(\$278,068)
South Carolina	\$27,393,627	\$40,193,208	\$39,203,128	(\$990,081)
South Dakota	\$5,596,267	\$8,194,820	\$7,984,471	(\$210,350)
Tennessee	\$33,810,254	\$49,700,774	\$48,524,851	(\$1,175,923)
Texas	\$182,673,808	\$268,930,020	\$262,775,790	(\$6,154,230)
Utah	\$18,400,600	\$26,993,085	\$26,325,488	(\$667,597)
Vermont	\$4,687,116	\$6,782,151	\$6,565,575	(\$216,576)
Virginia	\$26,169,053	\$38,456,811	\$37,540,957	(\$915,854)
Washington	\$36,823,713	\$53,791,976	\$52,343,146	(\$1,448,830)
West Virginia	\$9,372,560	\$13,740,453	\$13,396,041	(\$344,412)
Wisconsin	\$21,068,453	\$30,964,325	\$30,228,528	(\$735,798)
Wyoming	\$3,659,041	\$5,318,267	\$5,160,970	(\$157,297)
Indian Tribes	-	-	-	-
Migrant Program	-	-	-	-
Chicago	\$30,791,684	\$45,158,964	\$44,036,122	(\$1,122,842)
Houston	\$823,091	\$1,081,514	\$989,122	(\$92,391)
New York City	\$61,932,974	\$91,046,211	\$88,894,805	(\$2,151,406)
Philadelphia	\$16,384,722	\$23,942,149	\$23,301,162	(\$640,987)
San Antonio	\$18,064,594	\$26,549,301	\$25,918,286	(\$631,015)
American Samoa	\$887,460	\$1,302,445	\$1,270,530	(\$31,915)
Guam	\$1,727,117	\$2,517,687	\$2,447,112	(\$70,575)
Marshall Islands	-	-	-	-
Micronesia	-	-	-	-
Northern Mariana Islands	\$652,145	\$934,807	\$900,288	(\$34,519)
Palau	-	-	-	-
Puerto Rico	\$20,924,540	\$30,617,020	\$29,818,823	(\$798,197)
Virgin Islands	\$2,008,011	\$2,861,064	\$2,746,194	(\$114,870)
<b>Total States/Cities/Territories</b>	<b>\$1,763,839,474</b>	<b>\$2,590,493,000</b>	<b>\$2,527,987,000</b>	<b>(\$62,506,000)</b>
Technical Assistance	-	-	-	-
State Penalties	-	-	-	-
Contingency Fund	-	-	-	-
Other Adjustments <sup>1</sup>	\$309,273,526	\$314,837,000	\$233,970,000	(\$80,867,000)
<b>Subtotal Adjustments</b>	<b>\$210,455,526</b>	<b>\$314,837,000</b>	<b>\$233,970,000</b>	<b>(\$80,867,000)</b>
<b>Total Resources <sup>2</sup></b>	<b>\$1,974,295,000</b>	<b>\$2,905,330,000</b>	<b>\$2,761,957,000</b>	<b>(\$143,373,000)</b>

<sup>1</sup> Adjustments include costs associated with vaccines stockpile purchases, storage and rotations, special projects, and program support services.

<sup>2</sup> Approximately \$99 million of funds that were apportioned in FY 2006 were carried over to FY 2007, mainly due to some pediatric vaccine stockpile purchases being delayed to FY 2007.

SUPPLEMENTAL MATERIAL  
DETAIL OF FULL-TIME EQUIVALENT EMPLOYMENT (FTE)

**DETAIL OF FULL TIME EQUIVALENT EMPLOYMENT (FTE)**

FY 2008 BUDGET SUBMISSION CENTERS FOR DISEASE CONTROL AND PREVENTION			
DETAIL OF FULL TIME EQUIVALENT EMPLOYMENT (FTE) <sup>1</sup>			
	FY 2006 Actual	FY 2007 CR	FY 2008 Budget
Infectious Diseases	2,534	2,592	2,677
Health Promotion <sup>2</sup>	1,013	1,051	1,094
Health Information and Service	711	714	738
Environmental Health and Injury Prevention	490	495	513
Occupational Safety and Health	1,150	1,121	1,161
Global Health	78	92	95
Public Health Research	6	6	6
Public Health Improvement and Leadership	797	797	825
Preventive Health & Health Services Block Grant (PHHSBG) <sup>2</sup>	8	8	0
Business Services Support	895	895	926
Terrorism <sup>3</sup>	499	722	930
Agency for Toxic Substances and Disease Registry	330	330	330
<b>TOTAL, CDC/ATSDR FTE</b>	<b>8,510</b>	<b>8,823</b>	<b>9,295</b>

<sup>1</sup> FTE levels across CDC are projected to increase due to processing backlogged hiring actions in light of relief from hiring restrictions in FY 2006.

<sup>2</sup> The PHHSBG is eliminated in the FY 2008 Budget. As a result, FTE levels for Health Promotion include those from PHHSBG in FY 2008.

<sup>3</sup> FTE levels for Terrorism include proposed increases for assigning additional FTEs to Pandemic Influenza Planning and Preparedness which will require hiring scientific and public health personnel in FY 2007 to ensure CDC is able to effectively carry out its role in domestic and global preparedness. Terrorism preparedness activities and the Strategic National Stockpile (SNS) program are areas where a stable workforce is essential. Conversion of contractor SNS staff to federal employees to support state and local preparedness efforts is underway. Refer to the "New Positions Requested" exhibit for detailed numbers.

**DETAIL OF POSITIONS**

<b>FY 2008 BUDGET SUBMISSION</b> <b>CENTERS FOR DISEASE CONTROL AND PREVENTION</b> <b>PROGRAM ADMINISTRATION</b> <b>DETAIL OF POSITIONS</b>			
	<b>FY 2006</b> <b>Actual</b>	<b>FY 2007</b> <b>CR</b>	<b>FY 2008</b> <b>Budget</b>
<b>Executive Level</b>			
Executive level I			
Executive level II			
Executive level III			
Executive level IV			
Executive level V			
<i>Subtotal</i>	-	-	-
<b>Total-Executive Level Salary</b>			
	<b>Total - SES</b>	<b>31</b>	<b>31</b>
	<b>Total - SES Salary</b>	<b>\$4,695,841</b>	<b>\$4,822,629</b>
GS-15	478	478	478
GS-14	1,275	1,275	1,275
GS-13	2,045	2,045	2,045
GS-12	1,090	1,090	1,090
GS-11	693	693	693
GS-10	53	53	53
GS-9	437	437	437
GS-8	75	75	75
GS-7	397	397	397
GS-6	68	68	68
GS-5	73	73	73
GS-4	48	48	48
GS-3	30	30	30
GS-2	1	1	1
GS-1	0	0	0
<i>Subtotal</i>	<b>6,763</b>	<b>6,763</b>	<b>6,763</b>
<b>Total - GS Salary</b>	<b>\$548,932,489</b>	<b>\$561,009,003</b>	<b>\$577,839,273</b>
Average GS grade	11.9	11.9	11.9
Average GS salary	81,167	82,953	85,441
Average Special Pay Categories			
Average Comm. Corps Salary <sup>1</sup>	95,659	98,242	101,189
Average Wage Grade Salary	49,858	50,954	52,483

<sup>1</sup> Includes special pays and allowances.

**NEW POSITIONS REQUESTED**

**FY 2008 BUDGET SUBMISSION  
CENTERS FOR DISEASE CONTROL AND PREVENTION  
NEW POSITIONS REQUESTED**

	FY 2007 CR	FY 2008 Budget	FY 2008 +/- FY 2007
Terrorism - Strategic National Stockpile	80	110	30
Terrorism - Pandemic Influenza Planning and Preparedness	165	125	(40)
<b>Total</b>	<b>245</b>	<b>235</b>	<b>(10)</b>

**PERFORMANCE BUDGET CROSSWALK**

<b>FY 2008 BUDGET SUBMISSION</b> <b>CENTERS FOR DISEASE CONTROL AND PREVENTION</b> <b>PERFORMANCE BUDGET CROSSWALK</b> <b>(DOLLARS IN THOUSANDS)</b>				
Performance Program Area (PPA)	Budget Activity	FY 2006 Actuals	FY 2007 CR	FY 2008 Budget
Infectious Diseases	Infectious Diseases	\$1,695,156	\$1,658,626	\$1,794,368
Health Promotion	Health Promotion	\$958,025	\$958,687	\$958,732
Health Information and Services	Health Information and Services	\$218,905	\$218,966	\$243,496
Environmental Health and Injury and Prevention	Environmental Health and Injury and Prevention	\$287,474	\$287,674	\$287,674
Occupational Safety and Health	Occupational Safety and Health	\$262,883	\$252,999	\$252,998
Global Health	Global Health	\$379,624	\$310,420	\$379,719
Public Health Research	Public Health Research	\$31,000	\$31,000	\$31,000
Public Health Improvement and Leadership	Public Health Improvement and Leadership	\$264,106	\$189,236	\$190,412
Preventive Health & Health Services Block Grant	Preventive Health & Health Services Block Grant	\$98,932	\$99,000	\$0
Buildings and Facilities	Buildings and Facilities	\$158,291	\$133,638	\$20,000
Business Services Support	Business Services Support	\$317,576	\$317,781	\$319,877
Agency for Toxic Substance and Disease Registry	Agency for Toxic Substance and Disease Registry	\$74,905	\$74,905	\$75,004
Terrorism	Terrorism	\$1,631,173	\$1,543,947	\$1,504,375
<i>Total Request</i>		\$6,378,050	\$6,076,879	\$6,057,655

**SUMMARY OF FULL COST**

<b>FY 2008 BUDGET SUBMISSION CENTERS FOR DISEASE CONTROL AND PREVENTION SUMMARY OF FULL COST (DOLLARS IN MILLIONS)</b>			
<b>Performance Program Area</b>	<b>FY 2006</b>	<b>FY 2007</b>	<b>FY 2008</b>
<b>INFECTIOUS DISEASES<sup>1</sup></b>	\$3,647.0	\$3,976.3	\$4,502.9
<b>Immunization and Respiratory Diseases<sup>1</sup></b>	\$2,550.7	\$3,443.8	\$3,346.3
Goal 1 <sup>1</sup>	\$1,252.3	\$1,673.4	\$1,620.6
Measure 1	\$980.1	\$1,306.1	\$1,264.8
Measure 2	\$136.1	\$183.7	\$177.9
Measure 3	\$136.1	\$183.7	\$177.9
Goal 2 <sup>1</sup>	\$1,252.3	\$1,673.4	\$1,620.6
Measure 1	\$1,252.3	\$1,673.4	\$1,620.6
Goal 3	\$17.3	\$37.7	\$40.9
Measure 1	\$8.6	\$18.8	\$20.5
Measure 2	\$8.6	\$18.8	\$20.5
Goal 4	\$11.5	\$43.1	\$46.8
Measure 1	\$11.5	\$43.1	\$46.8
Goal 5 <sup>2</sup>	N/A	N/A	N/A
Measure 1	N/A	N/A	N/A
Goal 6	\$17.3	\$16.2	\$17.5
Measure 1	\$17.3	\$16.2	\$17.5
<b>HIV/AIDS, Viral Hepatitis, STD and TB Prevention</b>	\$1,052.2	\$1,038.4	\$1,112.9
<b>HIV/AIDS, Research and Domestic</b>	\$471.7	\$465.6	\$543.8
Goal 1	\$696.6	\$687.4	\$770.1
Measure 1	\$458.0	\$452.0	\$529.6
Measure 2	\$3.1	\$3.1	\$3.1
Goal 2	\$176.7	\$174.4	\$177.6
Measure 1	\$34.3	\$33.8	\$31.4
Goal 3	\$140.4	\$138.5	\$210.6
Measure 1	\$106.0	\$104.6	\$131.2
Measure 2	\$34.5	\$34.0	\$79.3
Goal 4	\$30.6	\$30.2	\$30.6
Measure 1	\$0.0	\$0.0	\$0.0
Goal 5	\$124.0	\$122.4	\$125.0
Measure 1	\$55.0	\$54.2	\$55.3
<b>Sexually Transmitted Diseases</b>	\$26.0	\$25.7	\$22.9
Goal 6	N/A	N/A	N/A
Measure 1	N/A	N/A	N/A
Measure 2	N/A	N/A	N/A
Goal 7	N/A	N/A	N/A
Measure 1	N/A	N/A	N/A
Measure 2	N/A	N/A	N/A
Goal 8	N/A	N/A	N/A
Measure 1	N/A	N/A	N/A
Goal 9	\$15.7	\$15.4	\$13.7
Measure 1	\$4.9	\$4.9	\$4.3
Measure 2	\$5.5	\$5.4	\$4.8
Measure 3	\$5.2	\$5.2	\$4.6
Goal 10	\$10.4	\$10.2	\$9.2
Measure 1	\$7.4	\$7.3	\$6.5
Measure 2	\$1.9	\$1.9	\$1.7
Measure 3	\$1.1	\$1.1	\$1.0
<b>Tuberculosis</b>	\$21.7	\$21.4	\$18.9
Goal 11	\$21.7	\$21.4	\$18.9
Measure 1	\$152.9	\$150.9	\$146.5
Measure 2	\$15.4	\$15.2	\$12.2
Measure 3	\$2.0	\$1.9	\$1.6
Measure 4	\$4.3	\$4.3	\$3.4
<b>Viral Hepatitis</b>	\$0.3	\$0.3	\$0.3
Goal 12	\$0.3	\$0.3	\$0.3
Measure 1	N/A	N/A	N/A
<b>Zoonotic, Vector-Borne, and Enteric Diseases</b>	\$44.0	\$43.1	\$43.6
Goal 1	\$44.0	\$43.1	\$43.6
Measure 1	\$21.1	\$20.6	\$20.9

FY 2008 BUDGET SUBMISSION  
CENTERS FOR DISEASE CONTROL AND PREVENTION  
SUMMARY OF FULL COST  
(DOLLARS IN MILLIONS)

Performance Program Area	FY 2006	FY 2007	FY 2008
<b>Preparedness, Detection, and Control of Infectious Diseases</b>	\$15.7	\$15.2	\$15.1
Goal 1	\$1.2	\$1.1	\$1.1
Measure 1	N/A	N/A	N/A
Measure 2	N/A	N/A	N/A
Measure 3	\$0.2	\$0.2	\$0.2
Goal 2	\$14.6	\$14.0	\$14.0
Measure 1	N/A	N/A	N/A
Measure 2	\$1.0	\$1.0	\$1.0
Goal 3 <sup>2</sup>	N/A	N/A	N/A
Measure 1	N/A	N/A	N/A
<b>HEALTH PROMOTION</b>	<b>\$579.3</b>	<b>\$690.8</b>	<b>\$685.6</b>
<b>Chronic Disease Prevention and Health Promotion</b>	<b>\$420.3</b>	<b>\$540.3</b>	<b>\$537.0</b>
Goal 1	\$32.8	N/A	N/A
Measure 1	\$19.8	N/A	N/A
Measure 2	\$13.0	N/A	N/A
Goal 2	\$30.3	N/A	N/A
Measure 1	\$30.3	N/A	N/A
Goal 3	\$111.9	N/A	N/A
Measure 1	\$55.6	N/A	N/A
Measure 2	\$13.6	N/A	N/A
Measure 3	\$14.2	N/A	N/A
Measure 4	\$14.2	N/A	N/A
Measure 5	\$14.2	N/A	N/A
Goal 4	\$57.5	N/A	N/A
Measure 1	\$22.9	N/A	N/A
Measure 2	\$13.0	N/A	N/A
Measure 3	\$10.5	N/A	N/A
Goal 5	\$84.7	N/A	N/A
Measure 1	\$84.7	N/A	N/A
Goal 6	\$47.0	N/A	N/A
Measure 1	\$36.5	N/A	N/A
Goal 7	\$30.9	N/A	N/A
Measure 1	\$15.5	N/A	N/A
Measure 2	\$15.5	N/A	N/A
Goal 8	\$25.3	N/A	N/A
Measure 1	\$12.7	N/A	N/A
Measure 2	\$12.7	N/A	N/A
New Goal 1	N/A	\$245.4	\$243.0
Measure 1	N/A	\$47.4	\$46.9
Measure 2	N/A	\$47.4	\$46.9
Measure 3	N/A	\$62.7	\$62.1
New Goal 2	N/A	\$79.5	\$76.6
Measure 1	N/A	\$39.7	\$38.3
Measure 2	N/A	\$39.7	\$38.3
New Goal 3	N/A	\$64.8	\$59.4
Measure 1	N/A	\$32.4	\$29.7
Measure 2	N/A	\$32.4	\$29.7
New Goal 4	N/A	\$43.2	\$42.8
Measure 1	N/A	\$21.6	\$21.4
Measure 2	N/A	\$11.2	\$11.0
Measure 3	N/A	\$11.2	\$11.0
New Goal 5	N/A	\$47.4	\$42.1
Measure 1	N/A	\$7.0	\$6.2
Measure 2	N/A	\$33.5	\$29.7
New Goal 6	N/A	\$60.0	\$73.2
Measure 1	N/A	\$17.4	\$17.3
Measure 2	N/A	\$17.4	\$17.3
Measure 3	N/A	\$13.2	\$13.1
Measure 4	N/A	\$2.1	\$6.9

SUPPLEMENTAL MATERIAL  
SUMMARY OF FULL COST

FY 2008 BUDGET SUBMISSION  
CENTERS FOR DISEASE CONTROL AND PREVENTION  
SUMMARY OF FULL COST  
(DOLLARS IN MILLIONS)

Performance Program Area	FY 2006	FY 2007	FY 2008
<b>Birth Defects, Developmental Disabilities, Disability and Health</b>	\$159.0	\$150.5	\$148.6
Goal 1	\$68.4	\$64.7	\$63.9
Measure 1	\$7.5	N/A	N/A
Measure 2	\$5.5	N/A	N/A
Measure 3	\$12.3	N/A	N/A
Measure 4	\$6.0	\$5.7	\$5.6
Measure 5	\$10.7	\$10.1	\$10.0
Measure 6	\$0.4	\$0.4	\$0.4
Measure 7	\$0.7	\$0.6	\$0.6
Goal 2	\$90.6	\$85.8	\$84.7
Measure 1	\$10.9	N/A	N/A
Measure 2	\$23.6	N/A	N/A
Measure 3	\$12.6	\$11.9	\$11.8
Measure 4	\$2.5	\$2.4	\$2.4
Measure 5	\$4.7	\$4.5	\$4.4
Measure 6	\$4.6	\$4.4	\$4.3
<b>HEALTH INFORMATION SERVICES</b>	\$187.6	\$184.9	\$181.7
<b>Health Statistics</b>	\$155.1	\$147.3	\$141.9
Goal 1	\$155.1	\$147.3	\$141.9
Measure 1	\$131.8	\$117.9	\$113.5
Measure 2	N/A	N/A	N/A
Measure 3	\$7.8	\$7.4	\$7.1
Measure 4	\$7.8	\$7.4	\$7.1
<b>Health Marketing</b>	\$32.5	\$37.5	\$39.8
Goal 1	\$7.2	\$11.7	\$16.4
Measure 1	\$7.2	\$11.7	\$16.4
Goal 2	\$19.9	\$18.8	\$18.7
Measure 1	\$9.9	N/A	N/A
Measure 2	\$9.9	\$18.8	\$18.7
Goal 3	\$5.4	\$7.0	\$4.7
Measure 1	\$5.4	\$7.0	\$4.7
<b>ENVIRONMENTAL HEALTH AND INJURY</b>	\$344.7	\$334.6	\$327.5
<b>Environmental Health</b>	\$185.8	\$180.1	\$174.7
Goal 1	\$76.2	\$73.8	\$71.6
Measure 1	\$13.0	\$12.6	\$12.2
Measure 2	\$7.4	\$7.2	\$7.0
Measure 3	\$18.6	\$18.0	\$17.5
Measure 4	\$5.6	\$5.4	\$5.2
Goal 2	\$102.2	\$99.0	\$96.1
Measure 1	\$39.0	\$37.8	\$36.7
Measure 2	\$42.7	\$41.4	\$40.2
Measure 3	\$3.7	\$3.6	\$3.5
Measure 4	\$3.7	\$3.6	\$3.5
Goal 3	\$7.4	\$7.2	\$7.0
Measure 1	\$3.7	\$3.6	\$3.5
<b>Injury Prevention and Control</b>	\$158.9	\$154.5	\$152.8
Goal 1	\$30.2	\$29.4	\$29.0
Measure 1	\$8.5	N/A	N/A
Measure 2	\$0.6	\$0.9	\$0.9
Goal 2	\$9.5	\$9.3	\$9.2
Measure 1	\$1.1	N/A	N/A
Goal 3	\$4.8	\$4.6	\$4.6
Measure 1	\$1.5	N/A	N/A
Goal 4	\$106.5	\$103.5	\$102.4
Measure 1	N/A	N/A	N/A
Measure 2	N/A	\$2.3	N/A
Goal 5	\$7.9	\$7.7	\$7.6
Measure 1	N/A	\$3.1	\$3.1
Measure 2	\$0.6	\$1.1	\$1.1
Measure 3	\$0.6	\$1.1	\$1.1

FY 2008 BUDGET SUBMISSION  
CENTERS FOR DISEASE CONTROL AND PREVENTION  
SUMMARY OF FULL COST  
(DOLLARS IN MILLIONS)

Performance Program Area	FY 2006	FY 2007	FY 2008
<b>OCCUPATIONAL SAFETY AND HEALTH</b>	\$368.2	\$345.4	\$324.7
<b>Occupational Safety and Health</b>	\$368.2	\$345.4	\$324.7
Goal 1	\$276.1	\$259.0	\$243.5
Measure 1	\$41.4	\$38.9	\$36.5
Measure 2	N/A	N/A	N/A
Measure 3	\$187.8	N/A	N/A
Measure 4	\$19.3	\$18.1	\$17.0
Measure 5	N/A	\$194.3	\$182.6
Goal 2	\$92.0	\$86.3	\$81.2
Measure 1	\$5.5	\$5.2	N/A
Measure 2	\$12.0	\$11.2	\$10.6
Measure 3	\$11.0	\$10.4	\$9.7
Measure 4	\$5.5	\$5.2	N/A
Measure 5	N/A	N/A	N/A
Measure 6	N/A	N/A	N/A
<b>GLOBAL HEALTH</b>	\$278.8	\$227.8	\$275.1
<b>Global Health - GAP</b>	\$128.2	\$104.8	\$126.5
Goal 1	N/A	N/A	N/A
Measure 1	N/A	N/A	N/A
Goal 2	\$83.6	\$68.3	\$82.5
Measure 1	\$10.0	\$8.2	\$9.9
Measure 2	\$5.9	\$4.8	\$5.8
Measure 3	\$7.5	\$6.2	\$7.4
Measure 4	\$5.9	\$4.8	\$5.8
Goal 3	\$44.6	\$36.4	\$44.0
Measure 1	\$5.4	\$4.4	\$5.3
Measure 2	\$3.1	\$2.6	\$3.1
Measure 3	\$4.0	\$3.3	\$4.0
Measure 4	\$3.1	\$2.6	\$3.1
<b>Global Health - Immunization</b>	\$150.5	\$123.0	\$148.6
Goal 4	\$105.9	\$86.6	\$104.5
Measure 1	\$19.1	\$14.7	\$17.8
Measure 2	\$20.1	\$17.3	\$20.9
Goal 5	\$44.6	\$36.4	\$44.0
Measure 1	\$5.8	\$4.7	\$5.7
Measure 2	\$0.9	\$0.7	\$0.9
<b>PUBLIC HEALTH IMPROVEMENT AND LEADERSHIP</b>	\$46.1	\$42.8	\$37.1
<b>Office of Minority Health</b>	\$2.8	\$2.8	\$2.8
Goal 1	\$0.6	\$0.6	\$0.6
Measure 1	\$0.1	\$0.1	\$0.1
Goal 2	\$0.6	\$0.6	\$0.6
Measure 1	\$0.1	\$0.1	\$0.1
Goal 3 <sup>2</sup>	-	-	-
Measure 1	-	-	-
Goal 4	\$1.5	\$1.5	\$1.5
Measure 1	\$0.4	\$0.4	\$0.4
Measure 2	\$0.4	\$0.4	\$0.4
<b>Office of Workforce and Development</b>	\$43.3	\$40.0	\$34.3
Goal 1	\$43.3	\$40.0	\$34.3
Measure 1	\$38.9	\$36.0	\$30.9
Goal 2 <sup>2</sup>	-	-	-
Measure 1	-	-	-

SUPPLEMENTAL MATERIAL  
SUMMARY OF FULL COST

FY 2008 BUDGET SUBMISSION  
CENTERS FOR DISEASE CONTROL AND PREVENTION  
SUMMARY OF FULL COST  
(DOLLARS IN MILLIONS)

Performance Program Area	FY 2006	FY 2007	FY 2008
<b>PREVENTIVE HEALTH AND HEALTH SERVICES</b>			
<b>BLOCK GRANT</b>	\$99.0	\$99.0	-
<b>TERRORISM</b>	\$1,474.6	\$1,400.3	\$1,358.6
Goal 2	\$72.6	\$69.0	\$66.9
Measure 1	\$0.7	\$0.7	\$0.7
Measure 2	\$25.9	\$24.6	\$23.9
Measure 3	\$25.9	\$24.6	\$23.9
Goal 3	\$48.9	\$46.5	\$45.1
Measure 1	\$5.0	\$4.7	\$4.6
Measure 2	\$5.0	\$4.7	\$4.6
Measure 3	\$3.9	\$3.7	\$3.6
Measure 4	\$2.2	\$2.1	\$2.0
Measure 5	\$2.2	\$2.1	\$2.0
Measure 6	\$5.0	\$4.7	\$4.6
Goal 4	\$7.9	\$7.5	\$7.3
Measure 1	\$0.6	\$0.6	\$0.6
Measure 2	\$4.2	\$4.0	\$3.9
Goal 5	\$44.2	\$42.0	\$40.7
Measure 1	\$0.4	N/A	N/A
Measure 2	\$6.5	\$6.1	\$5.9
Measure 3	\$6.5	\$6.1	\$5.9
Measure 4	\$4.4	\$4.2	\$4.0
Goal 6	\$500.5	\$475.3	\$461.1
Measure 1	\$5.0	\$4.8	\$4.6
Measure 2	\$5.0	\$4.8	\$4.6
Measure 3	N/A	N/A	\$173.4
Measure 4	\$30.0	\$28.5	\$27.7
Measure 5	\$30.0	\$28.5	\$27.7
Measure 6	\$188.2	\$178.7	\$173.4
Measure 7	\$5.0	\$4.8	\$4.6
Goal 9	\$800.5	\$760.1	\$737.5
Measure 1	\$498.7	\$473.6	\$459.5
Measure 2	\$4.8	\$4.6	\$4.4
Measure 3	\$240.1	\$228.0	\$221.3
Measure 4	\$37.6	\$35.7	\$34.7
<b>Total</b>	<b>\$7,040.9</b>	<b>\$7,866.1</b>	<b>\$7,708.3</b>

<sup>1</sup> Includes VFC funding.

<sup>2</sup> The activities covered by these goals & measures are funded by other areas within CDC.

N/A signifies retired goals and measures or measures not reported in a fiscal years.

CDC's Full Cost estimates for FY 2006 – FY 2008 were estimated by adding program management cost to the budget activities across CDC using the All Purpose Table. Program management costs included CDC's Leadership & Management and Business Services Support activities as well as Buildings & Facilities activities. Program management costs were allocated, where appropriate, across performance program areas based on the proportion of total program level cost represented by each program and performance program area. The full cost of each performance program area was then distributed by performance measures. These distributions are based on professional judgments, supported to the extent possible by financial and other statistical data. In many cases, performance measures are aggregated in the distributions of cost because of the interdependence of the activities and goals represented by the measures. The cost distributions by performance measures are presented for "active" measures in a given year. That is, measures that are to be deleted are included only for the applicable year(s) before their deletion; new measures are included beginning with the first year in which performance data are expected.

**CROSSWALK FUNDING BY PROGRAM AND ORGANIZATION (2006)**

FY 2008 BUDGET SUBMISSION CENTERS FOR DISEASE CONTROL AND PREVENTION FUNDING BY PROGRAM AND ORGANIZATION FY 2006 (DOLLARS IN THOUSANDS)													
	ATSDR	CCID <sup>1</sup>	CCHP	CCHIS	CCEHIP	NIOSH	COGH	COTPER	L&M	OD <sup>2</sup>	OWCD	BSS	Total
Infectious Diseases		1,695,156											1,695,156
Health Promotion			958,025										958,025
Health Information and Service				218,905									218,905
Environmental Health and Injury					287,474								287,474
Occupational Safety and Health						262,883							262,883
Global Health							379,624						379,624
Public Health Research										31,000			31,000
Public Health Improvement & Leadership									161,592	82,846	19,668		264,106
Prev. Hlth./Hlth. Services Block Grant			98,932										98,932
Building & Facilities										158,291			158,291
Business Services Support												317,576	317,576
Terrorism													1,631,173
Pandemic Influenza - FY 2006 One-Time Funding		50,000		27,000									77,000
Pandemic Influenza Second Supplemental										200,000			200,000
<b>Total, CDC</b>	<b>0</b>	<b>1,745,156</b>	<b>1,056,957</b>	<b>245,905</b>	<b>287,474</b>	<b>262,883</b>	<b>379,624</b>	<b>1,631,173</b>	<b>161,592</b>	<b>472,137</b>	<b>19,668</b>	<b>317,576</b>	<b>6,580,145</b>
Agency for Toxic Substances & Disease Registry	74,905												74,905
Vaccines For Children		1,974,295											1,974,295
<b>Total, CDC/ATSDR<sup>2</sup></b>	<b>74,905</b>	<b>3,719,451</b>	<b>1,056,957</b>	<b>245,905</b>	<b>287,474</b>	<b>262,883</b>	<b>379,624</b>	<b>1,631,173</b>	<b>161,592</b>	<b>472,137</b>	<b>19,668</b>	<b>317,576</b>	<b>8,629,345</b>

<sup>1</sup>Does not reflect the transfer of Vaccine safety activities from CCID to OD at this time. Vaccine safety activities were reorganized in a reprogramming letter submitted to and approved by Congress in FY 2005. These activities are now managed in the Office of the Director.

<sup>2</sup>Total for CDC/ATSDR does not include User Fees (\$2,226).

SUPPLEMENTAL MATERIAL  
CROSSWALK – FUNDING BY PROGRAM AND ORGANIZATION (2007)

**CROSSWALK FUNDING BY PROGRAM AND ORGANIZATION (2007)**

FY 2008 BUDGET SUBMISSION CENTERS FOR DISEASE CONTROL AND PREVENTION FUNDING BY PROGRAM AND ORGANIZATION FY 2007 <sup>1</sup> (DOLLARS IN THOUSANDS)													
	ATSDR	CCID <sup>2</sup>	CCHP	CCHIS	CCEHIP	NIOSH	COGH	COTPER	L&M	OD <sup>2</sup>	OWCD	BSS	Total
Infectious Diseases		1,658,626											1,785,684
Health Promotion			958,687										958,687
Health Information and Service				218,966									218,966
Environmental Health and Injury					287,674								287,674
Occupational Safety and Health						252,999							252,999
Global Health							310,420						310,420
Public Health Research									161,703	31,000			31,000
Public Health Improvement & Leadership				99,000						7,851	19,682		189,236
Prev. Hlth./Hlth. Services Block Grant										133,638			99,000
Building & Facilities													133,638
Business Services Support												317,781	317,781
Terrorism								1,543,947					1,543,947
<b>Total, CDC</b>	<b>0</b>	<b>1,658,626</b>	<b>1,057,687</b>	<b>218,966</b>	<b>287,674</b>	<b>252,999</b>	<b>310,420</b>	<b>1,543,947</b>	<b>161,703</b>	<b>172,489</b>	<b>19,682</b>	<b>317,781</b>	<b>6,001,974</b>
Agency for Toxic Substances & Disease Registry	74,905												74,905
Vaccines For Children		2,905,330											2,905,330
<b>Total, CDC/ATSDR<sup>3</sup></b>	<b>74,905</b>	<b>4,563,956</b>	<b>1,057,687</b>	<b>218,966</b>	<b>287,674</b>	<b>252,999</b>	<b>310,420</b>	<b>1,543,947</b>	<b>161,703</b>	<b>172,489</b>	<b>19,682</b>	<b>317,781</b>	<b>8,982,209</b>

<sup>1</sup>Funding in FY 2007 reflects the Continuing Resolution estimate.

<sup>2</sup>Does not reflect the transfer of Vaccine safety activities from CCID to OD at this time. Vaccine safety activities were reorganized in a reprogramming letter submitted to and approved by Congress in FY 2005. These activities are now managed in the Office of the Director.

<sup>3</sup>Total for CDC/ATSDR does not include User Fees (\$2,226).

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**CROSSWALK FUNDING BY PROGRAM AND ORGANIZATION (2008)**

FY 2008 BUDGET SUBMISSION CENTERS FOR DISEASE CONTROL AND PREVENTION FUNDING BY PROGRAM AND ORGANIZATION FY 2008 (DOLLARS IN THOUSANDS)													
	ATSDR	CCID <sup>1</sup>	CCHP	CCHIS	CCEHIP	NIOSH	COGH	COTPER	L&M	OD <sup>1</sup>	OWCD	BSS	Total
Infectious Diseases		1,794,368											1,794,368
Health Promotion			958,732										958,732
Health Information and Service				243,496									243,496
Environmental Health and Injury					287,674								287,674
Occupational Safety and Health						252,998							252,998
Global Health							379,719						379,719
Public Health Research										31,000			31,000
Public Health Improvement & Leadership									162,879	7,851	19,682		190,412
Prev. Hlth./Hlth. Services Block Grant													0
Building & Facilities										20,000			20,000
Business Services Support												319,877	319,877
Terrorism								1,504,375					1,504,375
<b>Total, CDC</b>	<b>0</b>	<b>1,794,368</b>	<b>958,732</b>	<b>243,496</b>	<b>287,674</b>	<b>252,998</b>	<b>379,719</b>	<b>1,504,375</b>	<b>162,879</b>	<b>58,851</b>	<b>19,682</b>	<b>319,877</b>	<b>5,982,651</b>
Agency for Toxic Substances & Disease Registry	75,004												75,004
Vaccines For Children		2,761,957											2,761,957
<b>Total, CDC/ATSDR<sup>2</sup></b>	<b>75,004</b>	<b>4,556,325</b>	<b>958,732</b>	<b>243,496</b>	<b>287,674</b>	<b>252,998</b>	<b>379,719</b>	<b>1,504,375</b>	<b>162,879</b>	<b>58,851</b>	<b>19,682</b>	<b>319,877</b>	<b>8,819,612</b>

<sup>1</sup> Does not reflect the transfer of Vaccine safety activities from CCID to OD at this time. Vaccine safety activities were reorganized in a reprogramming letter submitted to and approved by Congress in FY 2005. These activities are now managed in the Office of the Director.

<sup>2</sup> Total for CDC/ATSDR does not include User Fees (\$2,226).

SUPPLEMENTAL MATERIAL  
MECHANISM TABLE – BUDGET ACTIVITY

**MECHANISM TABLE BUDGET ACTIVITY**

<b>FY 2008 BUDGET SUBMISSION</b> <b>CENTERS FOR DISEASE CONTROL AND PREVENTION</b> <b>MECHANISM TABLE BY BUDGET ACTIVITY<sup>1</sup></b> <b>(DOLLARS IN THOUSANDS)</b>				
Budget Activity	FY 2006 Actual	FY 2007 CR	FY 2008 Budget	FY 2008 +/- FY 2007
<b>Infectious Diseases</b>	<b>\$1,695,156</b>	<b>\$1,658,626</b>	<b>\$1,794,368</b>	<b>\$135,742</b>
Intramural Research and Program Assistance	\$261,930	\$277,174	\$302,965	\$25,791
Extramural Programs	\$1,396,809	\$1,343,487	\$1,453,438	\$109,951
PHS Evaluation Transfers	\$36,417	\$37,965	\$37,965	\$0
<b>Health Promotion</b>	<b>\$958,025</b>	<b>\$958,687</b>	<b>\$958,732</b>	<b>\$45</b>
Intramural Research and Program Assistance	\$131,427	\$130,643	\$130,650	\$7
Extramural Programs	\$805,699	\$806,256	\$806,294	\$38
PHS Evaluation Transfers	\$20,899	\$21,788	\$21,788	\$0
<b>Health Information and Service</b>	<b>\$218,905</b>	<b>\$218,966</b>	<b>\$243,496</b>	<b>\$24,530</b>
Intramural Research and Program Assistance	\$152,192	\$137,044	\$152,621	\$15,577
Extramural Programs	\$64,796	\$79,923	\$88,876	\$8,953
PHS Evaluation Transfers	\$1,917	\$1,999	\$1,999	\$0
<b>Environmental Health and Injury Prevention</b>	<b>\$287,474</b>	<b>\$287,674</b>	<b>\$287,674</b>	<b>\$0</b>
Intramural Research and Program Assistance	\$104,986	\$106,811	\$106,811	\$0
Extramural Programs	\$176,222	\$174,330	\$174,330	\$0
PHS Evaluation Transfers	\$6,266	\$6,533	\$6,533	\$0
<b>Occupational Safety and Health</b>	<b>\$262,883</b>	<b>\$252,999</b>	<b>\$252,998</b>	<b>(\$1)</b>
Intramural Research and Program Assistance	\$174,555	\$170,521	\$170,521	\$0
Extramural Programs	\$88,329	\$82,478	\$82,477	(\$1)
PHS Evaluation Transfers	\$0	\$0	\$0	\$0
<b>Global Health</b>	<b>\$379,624</b>	<b>\$310,420</b>	<b>\$379,719</b>	<b>\$69,299</b>
Intramural Research and Program Assistance	\$90,780	\$72,396	\$90,136	\$17,740
Extramural Programs	\$282,061	\$230,952	\$282,511	\$51,559
PHS Evaluation Transfers	\$6,783	\$7,072	\$7,072	\$0
<b>Public Health Research</b>	<b>\$31,000</b>	<b>\$31,000</b>	<b>\$31,000</b>	<b>\$0</b>
Intramural Research and Program Assistance	\$2,976	\$2,976	\$2,976	\$0
Extramural Programs	\$28,024	\$28,024	\$28,024	\$0
PHS Evaluation Transfers	\$0	\$0	\$0	\$0
<b>Public Health Improvement &amp; Leadership</b>	<b>\$264,106</b>	<b>\$189,236</b>	<b>\$190,412</b>	<b>\$1,176</b>
Intramural Research and Program Assistance	\$206,106	\$149,621	\$150,554	\$933
Extramural Programs	\$57,575	\$39,172	\$39,415	\$243
PHS Evaluation Transfers	\$425	\$443	\$443	\$0
<b>Prev. Health &amp; Health Services Block Grant</b>	<b>\$98,932</b>	<b>\$99,000</b>	<b>\$0</b>	<b>(\$99,000)</b>
Intramural Research and Program Assistance	\$1,187	\$1,188	\$0	(\$1,188)
Extramural Programs	\$97,745	\$97,812	\$0	(\$97,812)
PHS Evaluation Transfers	\$0	\$0	\$0	\$0

SUPPLEMENTAL MATERIAL  
MECHANISM TABLE – BUDGET ACTIVITY

<b>FY 2008 BUDGET SUBMISSION</b> <b>CENTERS FOR DISEASE CONTROL AND PREVENTION</b> <b>MECHANISM TABLE – BY BUDGET ACTIVITY<sup>1</sup></b> <b>(DOLLARS IN THOUSANDS)</b>				
Budget Activity	FY 2006 Actual	FY 2007 CR	FY 2008 Budget	FY 2008 +/- FY 2007
<b>Building and Facilities</b>	<b>\$158,291</b>	<b>\$133,638</b>	<b>\$20,000</b>	<b>(\$113,638)</b>
Intramural Research and Program Assistance	\$158,291	\$133,638	\$20,000	(\$113,638)
Extramural Programs	\$0	\$0	\$0	\$0
PHS Evaluation Transfers	\$0	\$0	\$0	\$0
<b>Business Services Support</b>	<b>\$317,576</b>	<b>\$317,781</b>	<b>\$319,877</b>	<b>\$2,096</b>
Intramural Research and Program Assistance	\$302,967	\$303,163	\$305,163	\$2,000
Extramural Programs	\$14,608	\$14,618	\$14,714	\$96
PHS Evaluation Transfers	\$0	\$0	\$0	\$0
<b>Terrorism</b>	<b>\$1,631,173</b>	<b>\$1,543,947</b>	<b>\$1,504,375</b>	<b>(\$39,572)</b>
Intramural Research and Program Assistance	\$357,989	\$344,888	\$335,984	(\$8,904)
Extramural Programs	\$1,270,684	\$1,196,559	\$1,165,891	(\$30,668)
PHS Evaluation Transfers	\$2,500	\$2,500	\$2,500	\$0
<b>FY 2006 Pandemic Influenza One-Time Funding (DoD)</b>	<b>\$77,000</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
Intramural Research and Program Assistance	\$19,250	\$0	\$0	\$0
Extramural Programs	\$57,750	\$0	\$0	\$0
PHS Evaluation Transfers	\$0	\$0	\$0	\$0
<b>FY 2006 Pandemic Influenza Second Supplemental</b>	<b>\$200,000</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
Intramural Research and Program Assistance	\$44,200	\$0	\$0	\$0
Extramural Programs	\$155,800	\$0	\$0	\$0
PHS Evaluation Transfer	\$0	\$0	\$0	\$0
<b>CDC Budget Authority Total</b>	<b>\$6,580,145</b>	<b>\$6,001,974</b>	<b>\$5,982,651</b>	<b>(\$19,323)</b>
Intramural Research and Program Assistance	\$2,008,836	\$1,830,063	\$1,768,381	(\$61,682)
Extramural Programs	\$4,496,102	\$4,093,611	\$4,135,970	\$42,359
PHS Evaluation Transfers	\$75,207	\$78,300	\$78,300	\$0
<b>Agency for Toxic Substances and Disease Registry</b>	<b>\$74,905</b>	<b>\$74,905</b>	<b>\$75,004</b>	<b>\$99</b>
Intramural Research and Program Assistance	\$58,426	\$58,426	\$58,503	\$77
Extramural Programs	\$16,479	\$16,479	\$16,501	\$22
PHS Evaluation Transfers	\$0	\$0	\$0	\$0
<b>Vaccines for Children</b>	<b>\$1,974,295</b>	<b>\$2,905,330</b>	<b>\$2,761,957</b>	<b>(\$143,373)</b>
Intramural Research and Program Assistance	\$45,409	\$66,823	\$63,525	(\$3,298)
Extramural Programs	\$1,928,886	\$2,838,507	\$2,698,432	(\$140,075)
PHS Evaluation Transfers	\$0	\$0	\$0	\$0
<b>PHS Evaluation Transfers (non-add)</b>	<b>\$265,100</b>	<b>\$265,100</b>	<b>\$266,000</b>	<b>\$900</b>
Intramural Research and Program Assistance	\$145,540	\$145,540	\$146,034	\$494
Extramural Programs	\$119,560	\$119,560	\$119,966	\$406
PHS Evaluation Transfers	\$0	\$0	\$0	\$0
<b>CDC/ATSDR Program Level Total<sup>2</sup></b>	<b>\$8,629,345</b>	<b>\$8,982,209</b>	<b>\$8,819,612</b>	<b>(\$162,597)</b>
Intramural Research and Program Assistance	\$2,112,671	\$1,955,312	\$1,890,409	(\$64,903)
Extramural Programs	\$6,441,467	\$6,948,597	\$6,850,903	(\$97,694)
PHS Evaluation Transfers	\$75,207	\$78,300	\$78,300	\$0

<sup>1</sup> The intramural/extramural split for CDC's budget activities is an estimate and will be updated in the coming months.

<sup>2</sup> Funding levels do not include total amount for user fees (\$2,226).

## PRESIDENT'S MANAGEMENT AGENDA

### OVERVIEW

Included in this section are CDC's key program management activities to address key aspects of the President's Management Agenda (PMA). The activities below briefly describe CDC's progress in these areas and outline some important initiatives designed to further improve the agency's program management.

CDC has been actively pursuing goals and improvements related to the PMA for several years. For example, CDC decreased its proportion of administrative positions by six percent from 1997 to 2001. CDC has historically focused on keeping the agency market-based and efficient by having approximately 6,000 service contractor staff engaged to conduct commercially-oriented responsibilities. In addition, CDC established its Fiscal Management Excellence Initiative in 2000, which has further enhanced improvements in fiscal performance. CDC is organized to effectively address and lead PMA issues. For example, CDC has established a Management Council to help concentrate management attention on the PMA.

### PROGRESS ON PRESIDENT'S MANAGEMENT AGENDA

CDC made major achievements in addressing the President's Management Agenda (PMA) objectives. CDC has consolidated or restructured nearly 40 major human capital or business services improvements and more than doubled its supervisory ratio, thereby making the agency more efficient and effective. CDC has maintained its reasoned strategic planning approach in Competitive Sourcing for FY 2002 - FY 2005. Another major, successful effort is implementing HHS' Unified Financial Management System (UFMS) which integrates the Department's financial management structure and provides HHS leaders with a more timely and coordinated view of critical financial management information. Furthermore, CDC has made extraordinary progress in Expanded Electronic Government initiatives, such as consolidating IT infrastructure services, having a leadership role in the establishment of a multi-department architecture for the President's Biosurveillance Initiative, and being actively engaged in HHS' modernization efforts. CDC's efforts to integrate budget and performance have taken on increased significance as the agency continues work to implement a new strategy and organization under the Futures Initiative. Recently, the agency announced modernizations to enhance health impact, support the capacity to respond to public health emergencies, and to directly engage CDC's customers, the American public.

### STRATEGIC MANAGEMENT OF HUMAN CAPITAL INITIATIVE

CDC's significant growth in its workforce over the past years is attributable to an ever-expanding public health mission. From FY 1996 to present, the number of employees has grown from 6,406 to 9,130 - an increase of nearly 43 percent. This trend clearly reflects the agency's expanded disease prevention and control responsibilities. CDC's workforce is comprised of individuals working in over 170 job series with an emphasis on scientific and medical occupations. Approximately two-thirds of CDC employees work in the Atlanta headquarters area. However, the agency has a major presence (defined here as more than 50 employees) in such diverse geographical areas as Cincinnati, OH; Morgantown, WV; Hyattsville, MD; Pittsburgh, PA; Washington, D.C.; Spokane, WA; Durham, NC; and Fort Collins, CO. CDC's overseas presence will be up to 250 employees this year.

### WORKFORCE RESTRUCTURING

CDC continues to promote and enhance its Strategic Management of Human Capital initiatives in support of the PMA. These initiatives include reducing layering, eliminating administrative positions through consolidation, further improving our supervisory ratio, and supporting the transition of our workforce toward providing more frontline public health functions.

CDC had already consolidated most of its program support offices to eliminate duplication prior to the PMA. Centralized offices included equal employment opportunity, procurement, human resources, facilities operations, security and emergency preparedness, and others. This consolidation resulted in substantial savings and efficiencies. CDC has undertaken a wide range of additional administrative consolidations and business improvements.

#### Administrative Consolidations

- CDC more than doubled its supervisory ratio from 1:5.5 in 2002 to over 1:12.6 in 2006. This documents the overall success in flattening organizations, reducing management layers, and consolidating and/or restructuring administrative functions.
- CDC consolidated 13 information technology (IT) infrastructure functions, services, staff and fiscal resources into the new Information Technology Services Office (ITSO). This consolidation reduced operating costs by 30 percent and staff by 29 percent.

- A complex and innovative approach to administrative/management consolidation was used to functionally merge the Office of the Director (OD) in both ATSDR and NCEH into one unit. FTE savings of 18 percent (35 FTEs) have already been realized.
- CDC is effectively completing its Business Services Consolidation Plan. This is an overarching strategy, approved by HHS in July 2003, to reduce administrative positions, centralize reporting and supervisory relationships, and establish agency-wide shared services.
- CDC consolidated the agency's medical and professional inquiry hotlines. CDC awarded a performance-based contract for consolidated public and professional health information services reducing over 40 hotlines to one. This will expand services (24x365, multilingual, hearing impaired) and save about \$35 million over seven years.
- CDC consolidated graphics services across the agency in FY 2005. This action resulted in fiscal and staff savings, including savings expected from more efficient use of equipment, that can be redirected to mission direct activities.
- CDC completed the evaluation and detailed planning for the consolidation of professional training services. Implementation of consolidated professional training services across the agency is expected to be complete in FY 2006 - 2007. CDC has been working with HHS to implement the HHS Learning Management System.
- CDC completed the evaluation and detailed planning for consolidation of travel services in 2005 with associated fiscal and staff savings for redirection to mission direct activities. In FY 2006, CDC fully implemented e-travel services throughout the agency.
- CDC, with HHS' guidance, completed the restructuring of its human resources office to the HHS Atlanta Human Resources Center (AHRC). This human resources office restructuring eliminated 76 FTEs, reflecting a 30 percent staff reduction. Despite this reduction, the time from AHRC's receipt of a hiring request to the day the job offer is made was reduced by 47 percent between 2003 and 2004.
- CDC consolidated administrative functions in approximately 30 CDC/OD offices, reducing staffing from a baseline of 83 FTEs to 63, or a savings of 24 percent. This action resulted in savings that can be redirected to mission direct activities.
- As a result of these human capital and other CDC business services improvements, the agency has reduced its number of mission support (i.e., administrative) staff by approximately 900 as of the end of 2005. This reduction of mission support staff will allow the redirection of administrative staff positions to front line public health efforts.

#### Business Process Improvements

CDC successfully implemented a state-of-the-art financial system, UFMS in April 2005. UFMS is part of a multi-year effort initiated by Former Secretary Thompson. CDC went "live" with UFMS' General Ledger and Accounting for Pay System in October 2004. The grants interface (Grants Solution) was also implemented in the first quarter of FY 2005.

CDC is improving procurement and grants operations. Operational improvement opportunities have been identified that will result in increased employee productivity through workforce alignment, process redesign, and operational performance management. This effort has already resulted in new contract cycle time being reduced by 54 percent between FY 2003 and FY 2006.

CDC evaluated vaccine purchase processes and will streamline CDC's purchase of over half of the nation's childhood vaccines through its Vaccine Management Improvement Project.

The Office of Personnel Management approved CDC/ATSDR's plan to offer Voluntary Separation Incentive Payments (VSIPs), or buyouts, to staff who worked in mission support functions in FY 2005. Under the VSIP authority, 336 mission support staff separated during FY 2005. CDC's plan was to use the VSIPs to help implement major reorganizations and business services consolidations which resulted in significant business efficiencies and redeployment of positions to front line public health efforts. In FY 2006, 15 staff separated under VSIP.

CDC has effectively used Voluntary Early Retirement Authority (VERA) to reduce mission support staff and restructure efficiencies accordingly. In FY 2003, 73 staff accepted VERA. In FY 2004 and FY 2005, 39 and 93 staff, respectively, retired early under VERA. In FY 2006, 3 staff accepted VERA.

#### Delayering Actions

CDC has completed delayering the agency to no more than four management layers. In total, CDC abolished over 200 "Sections" in response to this initiative. This "Section" delayering has contributed to a 33 percent decrease in the

official number of organizational units at CDC since 2001. This agency-wide approach resulted in compressing the distance between citizens and decision-makers.

#### **FY 2007 ACTIVITIES**

- CDC will continue to flatten the agency by further improving its supervisory ratio.
- CDC/ATSDR will continue efforts to redirect more mission support staff to mission direct positions.
- CDC will strategically retrain and redeploy employees impacted by initiatives such as competitive sourcing, consolidations, and reduction of mission support positions.

#### **COMPETITIVE SOURCING INITIATIVE**

##### **COMPETITIVE SOURCING PLAN**

CDC developed a long range Competitive Sourcing plan to guide the program and the resulting competitions each year. This plan reflects consideration of where and how competitive sourcing can best further CDC's mission, human capital plans and maximize our savings potential. CDC has continually met the plans' goals and maintained "green" PMA scorecard performance ratings.

##### **COMPETITIONS**

In FY 2003, CDC completed five studies of its Facilitates Planning and Management Office. CDC prevailed in all five studies, indicating that through rigorous and complex analysis of work, CDC was performing at a cost to the taxpayer less than that of comparable service providers.

In FY 2004, CDC conducted six A-76 competitions involving a range of CDC staff. The specific competitions included: (1) Animal Care, (2) Laboratory, Glassware and Associated Laundry services, (3) Office Automation, (4) Printing (5) Materials Management and (6) Library Services. Again, except for the small printing streamlined study, five of the competitions resulted in in-house decisions. The Library Services performance decision was not announced until FY 2005. This record indicates that through rigorous and complex analysis of commercial work, CDC performs at a cost to the taxpayer less than that of other service providers.

In FY 2005, three new standard competitions were announced for Computer Clerk Support, Statistical Support, and Writer and Editor Services. All three competitions resulted in in-house decisions. These FY 2005 competitions included approximately 150 FTEs. In addition to the standard competitions, the CDC Information Technology Services Office was approved by OMB as a "restructuring" alternative to A-76 competitions. The organization will achieve comparable savings over the next five years.

In FY 2006, CDC maximized the opportunity to leverage the new "CDC Now" organizational structure and other reorganizations involving business service functions. This opportunity allows CDC to improve efficiency and effectiveness in the delivery of business services within new coordinating centers/coordinating offices. Proposals for High Performing Organizations (HPOs), an alternative to A-76 competition, have been developed and submitted to OMB for the Financial Management Budget Execution Services function and the Public Health Integrated Business Services initiative. These HPO proposals involve over 1,500 commercial FTEs and represent a significant opportunity for CDC to reduce cost in mission support functions and modernize business systems across the agency.

##### **COMPETITIVE SOURCING SAVINGS**

CDC savings that accrue from competitive sourcing are reinvested in mission-direct, public health activities. For example, reductions in FTEs associated with mission support functions will be redirected to activities such as epidemiology, laboratory science, medical officials, and pandemic preparedness teams. Information technology savings are used to fund projects that support Health IT, science and other core mission activities such as linking public health and electronic medical records. Similarly, as CDC's mission continually expands with new and re-emerging diseases and health risks, savings are effectively invested in meeting urgent challenges such as avian influenza, tsunami response teams, and hurricane disaster relief efforts. Moreover, new requirements are resulting from opening the new CDC laboratory facilities and Global Communications Center as part of our facilities modernization program. This will help make our health protection tools and information accessible to the global community. CDC is participating in independent audits sponsored by HHS to validate our performance and savings.

**IMPROVED FINANCIAL PERFORMANCE INITIATIVE**

**UNITED FINANCIAL MANAGEMENT SYSTEM (UFMS)**

The Unified Financial Management System (UFMS) is being implemented to replace five legacy accounting systems currently used across the Operating Divisions (Agencies). The UFMS will integrate the Department's financial management structure and provide HHS leaders with a more timely and coordinated view of critical financial management information. The system will also facilitate shared services among the Agencies and thereby, help management reduce substantially the cost of providing accounting service throughout HHS. Similarly, UFMS, by generating timely, reliable and consistent financial information, will enable the component agencies and program administrators to make more timely and informed decisions regarding their operations. UFMS has been in production for the CDC and FDA for over a year, with new functionality releases of Grants and IVR in October 2005 and eTravel in April 2006. The PSC implementation was moved to production on October 16, 2006.

The PSC has the responsibility for ongoing Operations and Maintenance (O & M) activities for UFMS. The scope of O & M services includes post deployment support and ongoing business and technical operations services. Post-deployment services include supplemental functional support, training, change management and technical help-desk services. On-going business operation services involve core functional support, training and communications, and help desk services. On-going technical services include the operations and maintenance of the UFMS production and development environments, on-going development support, and backup and disaster recovery services. In accordance with Federal and HHS policy, the UFMS application is under an approval to operate through February 16, 2007 by the designated Certifying Authority and Designated Approving Authority (DAA). The UFMS application will be approved for operation for 1 year after this date. After October 2007, when all OPDIVs will be operational on UFMS, then a 3-year certification will be completed. This approval to operate assures that the necessary security controls have been properly reviewed and tested as required by the Federal Information Security Management Act (FISMA). CDC requests \$6,205,562 to support these efforts in FY 2008.

With the implementation of a modern accounting system, HHS has efforts underway to consolidate and implement automated administrative systems that share information electronically with UFMS. These systems will improve the business process flow within the Department, improve Funds Control and provide a state of the art integrated Financial Management System encompassing Finance, Budget, Acquisition, Travel and Property. As the UFMS project is nearing completion, the integration of administrative systems is the next step in making these processes more efficient and effective. CDC requests \$511,580 to support these efforts in FY 2008.

With the implementation of UFMS, CDC continues to pursue an aggressive strategy to upgrade fiscal management activities by bridging UFMS to the analytical and reporting tools necessary to respond to complex financial management requirements. These analytical and reporting tools position CDC to respond to current, future and contingency financial management requirements. To accomplish this strategy, CDC planned a multi-phased approach to UFMS. In October 2004, CDC implemented core UFMS Phase I. Core UFMS Phase I Implementation entailed deploying the UFMS General Ledger and Accounting for Pay Systems. In addition, CDC deployed the UFMS Interim Grants Solution in December 2004. This covered more than 50 percent of the dollar and transaction volume of the agency. In April 2005, CDC completed the full UFMS financial and accounting implementation of Phase I which is the cornerstone for future UFMS development and follow-up activities.

Phase II of UFMS started in FY 2005 with continuation into FY 2006 and FY 2007. Phase II will entail multiple tasks to include exploring the possibility of moving CDC to a fully project centric environment, modification of CDC feeder systems to support this environment, and development of a CDC data warehouse that will merge programmatic and financial information for meaningful management reporting. To this end, CDC commissioned and completed a business case to identify timelines, accurate cost estimates, preferred functional and technical solutions and a strategic plan to accomplish these efforts. The business case is currently under consideration. Other activities that will be included in Phase II include piloting the MarkView Invoice Imaging system for UFMS and integrating a number of other departmental business systems with the UFMS core financials. These systems include E Gov Travel, Sunflower property management, IMPAC II for grants processing, iProcure/Prism for acquisitions and Learning Management System for Training. 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.

**HHS Consolidated Acquisition System**

The HHS Consolidated Acquisition System (HCAS) initiative is a Department-wide contract management system that will integrate with the UFMS. The applications within the HCAS are Compusearch PRISM and a portion of the Oracle Compusearch Interface (OCI). PRISM is a federalized contract management system that helps streamline the procurement process. The implementation of PRISM includes the functionality of contract writing, simplified acquisitions, electronic approvals and routing, pre-award tracking, contract monitoring, post award tracking, contract closeout and reporting. Major functions, once integrated with the UFMS, include transfer of iProcurement requisition

for commitment accounting and funds verification to PRISM and transmission of the award obligation from PRISM to Oracle Financials.

Benefits:

The following benefits will be realized by the Department and the individual OPDIVs/STAFFDIVs once the HCAS system is fully implemented:

- Commitment Accounting
- Integration to other HHS Administrative Systems
- Decreased Operational Costs
- Increased Efficiency and Productivity
- Improved Decision Making – Unified systems
  - Data Integrity
  - Reporting
  - Performance Measurement
  - Financial Accountability
- Standardization
  - Business Processes
  - Information Technology
- Consistent Customer Service Levels
- Refocus personnel efforts on value-added tasks
- Knowledge Sharing
- System Enabled Work
  - HHS Acquisition Personnel – contracting
  - Customers in requirement preparation – requisitioning
- Meets Organizational Drivers and Goals (President's Management Agenda, One-HHS, OMB Line of Business)

The HCAS team is working closely with the UFMS PMO and HHS PMO to ensure a smooth roll out of both PRISM and iProcurement. An integrated team, including personnel from UFMS, Acquisition and Assets has been formed to ensure maximum utilization of in-house expertise. CDC requests \$2,401,260 to support these efforts in FY 2008.

*FINANCIAL MANAGEMENT IMPROVEMENT*

In FY 2003, CDC successfully began issuing quarterly financial statements and accelerating the closing of accounting records at the end of the fiscal year. The use of automated tools has expedited the financial data consolidation process and streamlined financial statement preparation. CDC continues to prepare timely quarterly statements and implement reviews, checks, reconciliations, and functions analysis to ensure the accuracy and completeness of financial statements. CDC is also proceeding with its Financial Management Excellence Initiative to further improve financial operations by following guidelines set by PricewaterhouseCoopers and the U.S. General Accounting Office in their respective November, 2000 reports.

*ACCOUNTABILITY*

CDC participated in the HHS "top down" audit approach in FY 2003 through FY 2006 for which HHS received clean opinions. CDC will participate in the HHS "top-down" audit for FY 2007. Additionally, CDC received five consecutive clean audit opinions from FY 1998 through FY 2002 as 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 pursuant to the Federal Managers' Financial Integrity Act and OMB Circular A-123. CDC reports results to HHS in an annual report.

As part of the Corrective Action Plan, CDC anticipates UFMS-generated financial statements by the end of the first quarter in FY08. CDC is working with UFMS Global and contractors to devise an automated procedure for financial statement preparation.

#### ***EXPANDED E-GOVERNMENT INITIATIVE***

CDC's request includes funding to support the PMA's Expanding E-Government and Departmental enterprise information technology initiatives. The **CDC** will contribute **\$5,710,805** of its FY 2008 budget to support Department enterprise information technology initiatives as well as the President's Management Agenda (PMA) Expanding E-Government initiatives. Operating Division contributions are combined to create an Enterprise Information Technology (EIT) Fund that finances both the specific HHS information technology initiatives identified through the HHS Information Technology Capital Planning and Investment Control process and the PMA initiatives. These HHS enterprise initiatives meet cross-functional criteria and are approved by the HHS IT Investment Review Board based on funding availability and business case benefits. Development is collaborative in nature and achieves HHS enterprise-wide goals that produce common technology, promote common standards, and enable data and system interoperability. The HHS Department initiatives also position the Department to have a consolidated approach, ready to join in PMA initiatives.

Of the amount specified above, **\$1,534,959** is allocated to support the President's Management Agenda Expanding E-Government initiatives for FY 2008. The balance of the EIT fund will be used to support HHS-wide initiatives. The amount supporting the PMA E-Government initiatives as follows:

PMA e-Gov Initiative	FY 2007 Allocation	FY 2008 Allocation
Business Gateway	\$109,172	\$71,923
E-Authentication	\$0	\$24,456
E-Rulemaking	\$0	\$0
E-Travel	\$0	\$66,993
Grants.Gov	\$251,213	\$258,750
Integrated Acquisition	\$220,224	\$226,946
Geospatial LoB	\$59,357	\$61,138
Federal Health Architecture LoB	\$757,661	\$729,912
Human Resources LoB	\$17,771	\$17,771
Grants Management LoB	\$13,254	\$26,170
Financial Management LoB	\$13,778	\$23,620
Budget Formulation & Execution LoB	\$12,401	\$14,054
IT Infrastructure LoB	\$13,227	\$13,227
<b>TOTAL</b>	<b>\$1,468,058</b>	<b>\$1,534,959</b>

Prospective benefits from these initiatives are:

**Business Gateway:** Provides cross-agency access to government information including: forms; compliance assistance resources; and, tools, in a single access point. The site offers businesses various capabilities including: "issues based" search and organized agency links to answer business questions; links to help resources regarding which regulations businesses need to comply with and how to comply; online single access to government forms; and, streamlined submission processes that reduce the regulatory paperwork burdens. HHS' participation in this initiative provides HHS with an effective communication means to provide its regulations, policies, and forms applicable to the business community in a business-facing, single access point.

**E-Authentication:** Provides standards-based authentication architecture to support Federal E-Government applications and initiatives. It provides a uniform process for establishing electronic identity and eliminates the need for redundant solutions for the verification of identity and electronic signatures. E-Authentication's federated architecture also enables citizens and businesses to use credentials issued by commercial entities, such as financial

institutions, to conduct transactions with the government, eliminating the need for HHS to issue credentials for its systems.

E-Rulemaking: Provides citizens and organizations a single point of access to Federal rulemaking information. HHS posts all rulemaking notices on Regulations.gov. HHS and E-Rulemaking are in the requirements and planning process for migrating HHS docket-management process to the E-Rulemaking system.

E-Travel: The E-Travel Program provides a standard set of travel management services government-wide. These services leverage administrative, financial and information technology best practices. By the end of FY 2006, all but one HHS OPDIV has consolidated services to GovTrip and legacy systems retired. By May 2008, all HHS travel will be conducted through this single system and the last remaining legacy functions will be retired.

Grants.gov: Allows HHS to publish grant funding opportunities and application packages online while allowing the grant community (state, local and tribal governments, education and research organizations, non-profit organization, public housing agencies and individuals) to search for opportunities, download application forms, complete applications locally, and electronically submit applications using common forms, processes and systems. In FY 2006, HHS received over 56,000 electronic applications from the grants community via Grants.gov.

Integrated Acquisition Environment: Eliminated the need for agencies to build and maintain their own agency-specific databases, and enables all agencies to record vendor and contract information and to post procurement opportunities. Allows HHS vendor performance data to be shared across the Federal government.

Lines of Business-Human Resources Management: Provides standardized and interoperable HR solutions utilizing common core functionality to support the strategic management of Human Capital. HHS has been selected as a Center of Excellence and will be leveraging its HR investments to provide services to other Federal agencies.

Lines of Business-Geospatial One-Stop: Promotes coordination and alignment of geospatial data collection and maintenance among all levels of government: provides one-stop web access to geospatial information through development of a portal; encourages collaborative planning for future investments in geospatial data; expands partnerships that help leverage investments and reduce duplication; and, facilitates partnerships and collaborative approaches in the sharing and stewardship of data. Up-to-date accessible information helps leverage resources and support programs: economic development, environmental quality and homeland security. HHS registers its geospatial data, making it available from the single access point.

Lines of Business-Federal Health Architecture: Creates a consistent Federal framework that improves coordination and collaboration on national Health Information Technology ( HIT ) Solutions; improves efficiency, standardization, reliability and availability to improve the exchange of comprehensive health information solutions, including health care delivery; and, to provide appropriate patient access to improved health data. HHS works closely with federal partners, state, local and tribal governments, including clients, consultants, collaborators and stakeholders who benefit directly from common vocabularies and technology standards through increased information sharing, increased efficiency, decreased technical support burdens and decreased costs.

Lines of Business –Financial Management: Supports efficient and improved business performance while ensuring integrity in accountability, financial controls and mission effectiveness by enhancing process improvements; achieving cost savings; standardizing business processes and data models; promoting seamless data exchanges between Federal agencies; and, strengthening internal controls.

Lines of Business-Grants Management: Supports end-to-end grants management activities promoting improved customer service; decision making; financial management processes; efficiency of reporting procedure; and, post-award closeout actions. An HHS agency, Administration for Children and Families (ACF), is a GMLOB consortia lead, which has allowed ACF to take on customers external to HHS. These additional agency users have allowed HHS to reduce overhead costs for internal HHS users. Additionally, NIH is an internally HHS-designated Center of Excellence and has applied to be a GMLOB consortia lead. This effort has allowed HHS agencies using the NIH system to reduce grants management costs. Both efforts have allowed HHS to achieve economies of scale and efficiencies, as well as streamlining and standardization of grants processes, thus reducing overall HHS costs for grants management systems and processes.

Lines of Business-Budget Formulation and Execution: Allows sharing across the Federal government of common budget formulation and execution practices and processes resulting in improved practices within HHS.

Lines of Business-IT Infrastructure: A recent effort, this initiative provides the potential to leverage spending on commodity IT infrastructure to gain savings; to promote and use common, interoperable architectures that enable data sharing and data standardization; secure data interchanges; and, to grow a Federal workforce with interchangeable skills and tool sets.

## CDC Engagement in Government-Wide E-Gov Projects

CDC is actively engaged in eight of the federal E-Gov initiatives, namely Federal Health Architecture, CHI, e-Vitals, e-Grants, e-Travel, Geospatial Information One Stop, SAFECOM, and GovBenefits, with an initial 16 CDC programs represented covering \$4.4 billion. CDC has actively advanced e-commerce using FedBizOpps to post all contract opportunities electronically. CDC has migrated to HHS' enterprise-wide grants management system for research grants using NIH's ERA (IMPAC II) system and has migrated other grants to the same system in FY 2006. CDC is co-chairing the FHA surveillance working group and has actively participated in the interoperability working group and the data architecture working group. CDC met the October 2003 goal for the Government Paperwork Elimination Act to make all information collections and disseminations available electronically.

## CDC E-GOV Initiatives

### *ENTERPRISE ARCHITECTURE*

CDC continues to advance in its Enterprise Architecture (EA) development. Recent accomplishments include ongoing work of CDC's Enterprise Architecture Board (EAB) made up of Agency-wide representatives; closer linkage with the Capital Planning and Investment Control (CPIC) process; and actively contributing to HHS' EA Model Working Group and EA Review Board. The resulting effort has raised CDC to Level 3 of OMB Enterprise Architecture Assessment Framework (EAAF). In addition to modeling CDC's Health Alerts Domain, the EA team has expanded its guidance into other key public health related functions, such as laboratory informatics.

### *SECURITY*

CDC actively participates in the HHS Secure One program by maturing its strong information security program which is comprised of a Certification and Accreditation (C&A) and security assessment program, information security awareness training, policy development, test and evaluation, and security operations activities. CDC has focused on increasing effectiveness and efficiencies this year by identifying common controls that can be applied across the enterprise and beginning to implement master system security plans that take advantage of those security controls to meet NIST requirements. CDC again completed Business Continuity Planning and testing for all of the 24 Federal Information Security Management Act (FISMA) critical systems and Business Continuity activities continue on an ongoing basis. CDC has further refined its Plan of Action and Milestone program to manage, mitigate, and validate remediation of system and enterprise weaknesses.

### *HHS MODERNIZATION*

#### Government-Wide E-Gov Projects

CDC is actively engaged in eight of the federal E-Gov initiatives, namely Federal Health Architecture, CHI, e-Vitals, e-Grants, e-Travel, Geospatial Information One Stop, SAFECOM, and GovBenefits, with an initial 16 CDC programs represented covering \$4.4 billion. CDC has actively advanced e-commerce using FedBizOpps to post all contract opportunities electronically. CDC has migrated to HHS' enterprise-wide grants management system for research grants using NIH's ERA (IMPAC II) system and has migrated other grants to the same system in FY 2006. CDC is co-chairing the FHA surveillance working group and has actively participated in the interoperability working group and the data architecture working group. CDC met the October 2003 goal for the Government Paperwork Elimination Act to make all information collections and disseminations available electronically.

#### IT Infrastructure Consolidation

CDC consolidated the agency's IT infrastructure functions, services, staff, and fiscal resources in accordance with OMB and HHS instructions. CDC has reduced costs by 38 percent and reduced staff by 29 percent in line with the overall agency reduction in mission support staffing. The 13 functions defined as IT infrastructure are: desktop computing support, directory services, e-mail, helpdesk support, infrastructure software, IT security, networking, data center services, office automation, remote access, server management, videoconferencing, and telecommunications.

#### Citizen-Centered Service

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 13 million different visitors per month on average. After Hurricane Katrina, over 22 million visited the site in September 2005 and 20 million visited due to influenza in November 2005.

CDC consolidated all of its more than 40 health information hotlines and clearinghouses into one consolidated consumer response service at 1-800-CDC-INFO. The service went live in March 2005 with the initial conversion of HIV/AIDS, STDs, and immunization hotlines. Additional health topic areas have been successfully converted such as Emergency Preparedness, Cancer, Physical Activity and Nutrition, Diabetes and School Health, Birth Defects, Smoking and Health, Injury, TB, and Environmental Health. Currently, there are 3,794 prepared responses available in the data base to support programs that have already transitioned. The new service handles public inquiries 24 hours per day, every day, in bilingual and services hearing impaired callers. The contact center handled greater than 550,000 calls and 11,000 emails during the first year of operation and is continually growing as new health topics are added to the contact service.

#### **FEDERAL REAL PROPERTY ASSET MANAGEMENT INITIATIVE**

In compliance with the Federal Real Property Asset Management Initiative, CDC has established a Senior Real Property Officer and a Federal Real Property Council to ensure that the CDC is meeting the guidelines that have been established by the initiative:

- *Senior Real Property Officer*- This Officer was designated to serve as the senior manager tasked with developing and implementing an agency asset management plan. Specifically, the Officer will: identify and categorize any real property owned, leased, or otherwise managed by the agency; prioritize actions to be taken to improve the operational and financial management of inventory; make life-cycle cost estimations associated with the prioritized actions; identify legislative authorities that are required to address the priorities; identify and pursue goals and targets with appropriate time frames and deadlines; provide advice on adequate budget amounts for activities; and focus on those activities and efforts allowed under current law.
- *Federal Real Property Council*- This Council will serve as a working group to facilitate the success of the agency's asset management plans. The Council will be composed of all agency Senior Real Property Officers, the Controller of the Office of Management and Budget, and the Administrator of General Services. The Deputy Director for Management of the Office of Management and Budget will be a member and serve as the chair of the Council. The Council will establish appropriate performance measurements for evaluating the costs and benefits involved with acquiring, repairing, maintaining, operating, managing, and disposing of Federal real properties at particular agencies. The Council will also serve as a clearinghouse for best practices in evaluating actual progress in the implementation of real property enhancements.

#### **BUDGET AND PERFORMANCE INTEGRATION INITIATIVE**

CDC's efforts to integrate budget and performance have increased as the agency implements a new strategy and organization. The agency continues to modernize to enhance health impact, support the capacity to respond to public health emergencies, and directly engage CDC's customers, the American public.

Across CDC, integration efforts are reflected in the development of the agency's Performance Budget. This document aggregates performance information, required under the Government Performance and Results Act (GPR), with budget information. The Performance Budget reflects:

- an emphasis on outcome-oriented measures that demonstrate the focus of CDC's programs.
- efficiency measures for all programs, per OMB instruction via the Program Assessment Rating Tool (PART) review.
- full costs calculated at the goal and performance measure level.
- coordination across CDC throughout the development of the FY 2008 Performance Budget and other integration activities.

#### **SENIOR AGENCY MANAGER MEETINGS**

CDC has implemented a Senior Agency Management retreat cycle to review its goals and objectives and the financial and performance information needed to accomplish them. The Executive Leadership Board (ELB) met in early January. The Center Leadership Council (CLC) met in late January and CDC Division Directors met in early February. Managers discussed annual goal plans, how effective CDC was in meeting those goals, how CDC's budget is aligned with goals, and what measures should be implemented in future years to improve the effectiveness of the agency in accomplishing its goals.

In addition, CDC has aligned agency PART measures with the CDC goal areas. Each ELB member with responsibility for a goal area will report on performance to other Board members.

Senior Agency managers from CDC's Financial Management Office (FMO), Office of Strategy and Innovation (OSI), and Coordinating Office of Terrorism Preparedness and Emergency Response (COTPER) collaborated on the FY 2006 spend-plan process. The spend plan process was formulated to fund programs based on performance rather than allocation and is intended to map program success and methods used to budget and track resources contributing to health impacts. COTPER and OSI reviews and evaluates projects and provides recommendations on funding. Projects recommended for funding were submitted to FMO for a detailed review of the project budget, and finally, submitted to the Executive Leadership Board and HHS for final approval.

Additionally, senior managers from CDC's OSI, FMO, COPTER, Procurement and Grants Office (PGO), and the Management Information Systems Office (MISO) collaborated to develop FY 2006 joint planning activities for budget, goals, and extramural awards. This collaborative effort created a single planning process supported by Integrated Resources Information System (IRIS), budget and performance integration, and CDC's newly created health impact web-based system that will link resources to performance. CDC's health impact system is a tool which will allow staff to track projects, performance, budget, and health impact through a uniform electronic system across the agency.

CDC leadership held meetings to discuss the best strategies to fully implement the HHS Performance Management Appraisal Program. Part of the meetings were dedicated to finalizing a timeline for CDC policy development and analyzing historical funding data related to the new percentages of awards to forecast for budget impact in FY 2007.

Monthly and ad hoc financial management meetings occur at all levels of the organization with and between Coordinating Center Directors, Chief Management Officials, Division Directors and Branch Chief to define and establish clear objectives for both program and budget. Regular meetings are scheduled reinforcing or modifying goals as program and financial situations change.

## PART

In 2002 through 2006, 22 CDC programs participated in a PART review by OMB: 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, STD/TB, Environmental Health, Global AIDS, in conjunction with the President's Emergency Plan for AIDS Relief, Global Immunization, Health Statistics and the Strategic National Stockpile, Chronic Disease Prevention and Health Promotion, Birth Defects and Developmental Disabilities, Injury Prevention and Control, BioSurveillance and Upgrading CDC Capacity. These programs have developed performance measures which are reported on in each submission of the performance budget. Many of the performance measures are outcome-oriented and support the direction of CDC's goals process. Many programs reviewed by PART have made improvements in strategy, program management and results based on OMB's recommendations. For example:

- CDC has initiated a business improvement project to revamp the entire vaccine distribution process which will strengthen the efficiency and accountability of vaccine management systems. Once fully implemented, the new systems will automate and integrate vaccine ordering and management by centralizing distribution of all public purchased vaccines.
- Breast and Cervical Cancer performance targets were increased in accordance with data submitted by the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) Federal Advisory Committee. This review was solicited as an independent verification of the effectiveness of the program in general, and a report of the first 12 years of the Breast and Cervical Cancer program was prepared and endorsed.
- CDC's Diabetes program completed a management analysis to determine how resources (i.e. human capital, time and funds) are being used to achieve National Program Objectives (NPO). The analysis successfully captured the internal and external influence, interaction and impact of resources.
- CDC's Domestic HIV/AIDS Prevention program developed a template for project officers' use to analyze progress reports from state health departments, Community-Based Organizations and providers. CDC is phasing-in the implementation of the Program Evaluation and Monitoring System (PEMS) which will allow CDC to augment qualitative data from grantee annual progress reports with quantitative data to show client and program effectiveness.
- CDC's Environmental Health program and ATSDR initiated an intramural review program to evaluate all of its activities and projects with the goal of identifying shortcomings and making recommendations for improvement. This program is conducted by the Peer Review Subcommittee of their Board of Scientific Counselors, an independent organization whose charter is to provide guidance to the program. The subcommittee will evaluate the entire Environmental Health program within the next five years.
- CDC has entered into a contract with the National Academies (NA) to conduct a comprehensive review of its occupational safety and health research program portfolio. In FY 2005, the NA Framework Committee established comprehensive evaluation criteria. To conduct the first phase of review, a NA evaluation panel

was assembled and employed the criteria to review mining and hearing loss prevention. NA panels are in the process of reviewing the mining and hearing loss programs and will provide a formal report with ratings in September 2006.

- ATSDR implemented a new long-term outcome measure for documenting the effectiveness of its interventions at sites that pose the most urgent public health hazards. ATSDR now evaluates its interventions at each site to determine their impact on public health. As a result, this new measure has focused the agency's leadership, its Cooperative Agreement Partners, and EPA on achieving public health outcomes.
- Critical tasks and performance measures were developed for the Public Health Emergency Preparedness Cooperative Agreement Program and were incorporated into the grant guidance for FY 2005.
- CDC's Occupational Safety and Health program initiated a contract with the National Academy of Sciences to conduct a comprehensive evaluation of the impact and relevance of occupational safety and health research.
- CDC's Infectious Diseases program has a website to post performance data on the grantee profile pages, including funding, activities funded, links to the grantees home page, grantee contact information and Congressional summaries (available for a limited number of grantees).
- CDC's TB program began to award state health department cooperative agreements for a new project cycle utilizing a new funding formula based on the burden of the disease.

#### Efficiency Measures

All CDC PART programs have at least one OMB-approved efficiency measure. These efficiency measures, along with their targets and actual performance, can be found in the Detail of Performance Analysis sections of this document.

#### *FULL COST*

CDC continues to report the full costs calculated at the goal and performance measure level in the Performance Budget. The full cost table has been changed to include the allocation of costs to the Vaccines for Children Program.

#### ***FAITH-BASED AND COMMUNITY INITIATIVE***

CDC/CCHIS/NCHM's Division of Partnerships and Strategic Alliances Faith Based and Community Organization (FBCO) Team was established to facilitate the development of partnerships between public health and FBCOs in order to provide more effective health and human services.

**Prepare for an Influenza Pandemic:** Deploy a national communications strategy to provide accurate, timely, consistent, and comprehensive information about preparing for and responding to influenza and pandemic influenza to the public, the news media, health care providers, and other partners and stakeholders.

- Collaboration between FBCOs and CDC's Emergency Communications System. CDC led a series of focus groups about how best to communicate with FBCOs during emergencies. Invited participants included: the Church of Jesus Christ of Latter-Day Saints, the Salvation Army, the National Council of Churches' Church World Service, the Hindu nonprofit charity BAPS Care International, the United Way of America, the United Methodist Committee on Relief, the African Methodist Episcopal (AME) Church, CAUSE-NY/Jewish Community Relations Council of NY; the Emory Interfaith Health Program; the National Voluntary Organizations Active in Disaster (National VOAD); the Regional Council of Churches of Atlanta, Inc. and Southern Baptist Disaster Relief.

**Enhance Emergency Response:** Prepare faith-based and community organizations to prevent and address the health effects of a disaster. CDC has increased the nation's preparedness for a potential influenza pandemic and other health emergencies by:

- Serving as the lead author for the HHS Faith-based and Community Organization Pandemic Influenza Preparedness Checklist released by Secretary Leavitt on January 10, 2006. This checklist is a resource to provide various FBCOs with broad guidance on how to begin planning for pandemic influenza. The checklist has widespread geographic distribution and has been used by many diverse organizations. More than 61,000 FBCOs refer to or link to the checklist.
- Serving as the lead agency for the October 5-6, 2006 Roundtable discussions with FBCOs about pandemic influenza preparedness. At the request of the White House Homeland Security Council, CDC served as lead organizers working with the HHS Center for Faith Based and Community Initiatives and other federal

agencies to host roundtable discussions with faith-based, community-based, volunteer, and non-profit organizations about ways to reduce a severe flu pandemic.

- Participants included individuals from these and many other organizations: the African Methodist Episcopal Church (AME), the American Red Cross, Asbury Theological Seminary, the Church of Jesus Christ of Latter-Day Saints, the Jewish Community Relations Council, the Muslim Women's Institute for Research and Development, the National Council of the Churches of Christ in the USA, National 4-H Clubs, the Southern Baptist Convention, United Jewish Communities, the United Way of America, the Urban Institute and World Vision International.
- Developing a Partnership with the National Voluntary Organizations Active in Disaster (National VOAD). CDC established and oversees monthly conference calls with the National VOAD, an umbrella organization of over 40 nonprofit and faith-based agencies that regularly participate in disaster response. The American Red Cross and the National VOAD are the only nongovernmental organizations that are signatories to the National Response Plan. The National Response Plan does not name charities active in disaster relief other than the American Red Cross, but instead incorporates them into the National VOAD.
- Organizing a Pandemic Planning Webinar with National VOAD. On December 8, 2006, CDC delivered a pandemic planning Webinar with the National VOAD member organizations and others.
- Organizing a Pandemic Planning Webinar for National Jewish Organizations. On December 5, 2006, CDC delivered a pandemic planning Webinar for National Jewish Organizations. Over 130 Jewish Federations from across North America participated.
- Developing a Partnership with the Islamic Medical Association of North America (IMANA). CDC is collaborating on pandemic influenza preparedness planning with IMANA, a Muslim nonprofit public charity active in health initiatives and other humanitarian efforts.
- Developing a Partnership with BAPS Care International: CDC is collaborating on pandemic influenza preparedness planning with BAPS Care International which is a Hindu 501(c) (3)-registered nonprofit international public charity active in health and disaster relief efforts.
- Developing a pandemic planning course for FBCOs in partnership with the Extension Disaster Education Network (EDEN). CDC is working with EDEN to develop a pandemic influenza training that will be delivered through the Land Grant University system which includes Land Grant Universities in each of the 50 states and extension agents in the counties of each of the states.
- Delivering numerous presentations about pandemic planning and emergency preparedness to FBCOs. For example, CDC staff will give a presentation on Pandemic Influenza Preparedness at the Progressive National Baptist Convention, Inc. Christian Education Summit in January 2007 in Houston, Texas. This network includes 2.5 million pastors, teachers and leaders in African American communities across the U.S., United Kingdom, Africa, Bahamas, Cuba and throughout the world.

**Emphasize Faith Based and Community Solutions:** Meet the OMB mandated "Green" Standards for Success and Best Practices Referenced in Standards. CDC has taken several critical steps to ensure that it is meeting the OMB "Green" Standards for Success by:

- Participation in the FY 2006 Annual Report to the White House Office of Faith-Based and Community Initiatives data collection efforts.
- Reporting efforts to educate agency staff on the requirements of the HHS Equal Treatment Regulations.
- Supporting numerous White House Office of Faith-Based and Community Initiatives Regional Conferences and Workshops. These targeted workshops are designed to help FBCOs learn more about President Bush's Faith-Based and Community Initiative and offer grant writing tutorials for certain Federal grant programs that present some of the greatest opportunities for FBCOs.
- Referring FBCOs to sign up for the HHS CFBCI Weekly Digest for Faith-Based and Community Organizations. This weekly digest summarizes grant opportunities at CDC and HHS for which faith-based/community organizations are eligible to apply.
- Collaborating with other federal agencies and offices on Grant Writing Workshops for FBCOs and panel reviews, for example:
  - On March 28-30, 2006, attended the Faith-Based and Community Partners' Grant writing and Fund Development Project sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA).

- On May 10-11, 2006, attended U.S. Department of Housing and Urban Development, Atlanta Regional Office, Region IV- Grant Writing Workshop
- On July 17-28, 2006, provided staff to serve as a Priority Area Manager for HHS Administration for Children & Families Compassion Capital Fund mini-grant & youth gangs programs' panel reviews.

**Support community-based approaches to reduce health disparities that affect racial, ethnic, and under- served populations.** Some examples of community-based approaches to reduce health disparities include the following:

- Rapid HIV testing initiative with African American Churches for 2007 National Black HIV/AIDS Awareness and Information Day. CDC is leading a collaborative project involving Recovery Consultants of Atlanta, Inc., the Institute for Health Protection, the United Way of Atlanta, CDC National Center for HIV, Hepatitis, STD and TB Prevention, SAMHSA, CMS, the African Methodist Episcopal (AME) church and the Interdenominational Theological Center on a Rapid HIV testing initiative with African American Churches as part of the 2007 National Black HIV/AIDS Awareness and Information Day.
- Presentation at the 2007 National Immunization Conference. From 1995 to 2005, while immunization rates for recommended childhood vaccines increased approximately 20% nationally, they increased more than 30% in Jefferson County, AL. This presentation will discuss Shepherd's Watch, a partnership between the Jefferson County Health Department and 38 churches representing diverse racial/ethnic communities. The county health department facilitated partnerships between eight churches and five medical centers to host eight free immunization clinics in urban areas; provided Shepherd's Watch partners with quarterly updates on immunization activities and recommendations; provided education to over 15,000 congregants; and gave technical assistance on how to implement immunization follow-up programs.
- Two-day consultation meeting on Faith and HIV Prevention. In February 2006, CDC's National Center for HIV/AIDS, STD, and TB Prevention held a two-day consultation meeting with 29 leaders from many faiths, including Protestant, Catholic, Jewish, Hebrew-Israelite, Muslim, and Buddhism.
- National Coalition of Pastors' Spouses. CDC's National Diabetes Education Program is working with the National Coalition of Pastors' Spouses, a national health and wellness initiative embedded in African American churches which focuses on health disparities.
- AME Church, 2006 influenza vaccination clinic pilot. Staff from CDC's National Center for Immunizations and Respiratory Diseases provided technical assistance to AME health officials as part of AME Church's influenza vaccination campaign.
- Samuel DeWitt Proctor Conference. In February 2007, CDC's Emergency Communications System will present on emergency communications, including pan flu at a session entitled "Emergency Preparedness Is Not An Option" during this nationally known Faith-based conference involving historically African-American churches.
- CDC session at 2006 Global Summit on AIDS and the Church. Various CDC staff presented a session at the Global Summit on AIDS and the Church, Nov. 30-Dec. 1, 2006. The Purpose Driven network includes over 400,000 church leaders and congregations in every country. CDC presented information about HIV/AIDS, malaria, tuberculosis, and diseases from unsafe water affecting vulnerable populations in developing countries.
- Safe Water Projects with FBCOs. CDC is working with Emory University School of Public Health, Emory Interfaith-Health Program, CARE and other international NGOs and FBCOs to identify ways to equip FBCOs for Safe Water Projects which aid vulnerable populations in developing countries.
- FBCO Personal Health Record Initiative. This initiative will illuminate how Personal Health Records (PHRs) can empower and improve the quality and efficiency of health care for African Americans, as well as, how social and physical transactions among clergy, congregants and the community can influence PHR adoption in the African American community

**Inform and educate federal grantees, including state and local officials who administer funds, about the requirements of the Equal Treatment regulations.** The HHS Equal Treatment Regulations are designed to remove barriers to the participation of FBCOs in HHS programs. CDC ensures that staff and partners are aware of these regulations in several ways:

- CDC distributed the HHS Equal Treatment Regulations through the Association of State and Territorial Health Officials, the National Association of Local Boards of Health, and the National Association of City and County Health Officials to state and local public health agencies administering CDC grants/cooperative agreements

- CDC distributed the HHS Equal Treatment Regulations to each of the CDC Faith-Based and Community Initiative Coordinators, the official point of contact for all FBCI activities within each CIO
- CDC has included the HHS Equal Treatment Regulations in the 2006 CDC Partnership Toolkit developed by the Division of Partnerships and Strategic Alliances
- CDC hosted Mr. Greg Morris, Director of the HHS Center for FBCI and his staff, who presented on the HHS Equal Treatment Regulations at the August 2006 CDC FBCI Coordinators monthly meeting in Atlanta, GA
- A link to the HHS Equal Treatment Regulations will be posted on the CDC intranet