PUBLIC HEALTH SCIENTIFIC SERVICES

(dollars in thousands)	FY 2010 Enacted	FY 2011 Continuing Resolution	FY 2012 President's Budget	FY 2012 +/- FY 2010
Budget Authority	$160,582	$160,601	$205,942	+$45,360
PHS Evaluation Transfer	*$247,769*	*$247,769*	*$217,674*	*-$30,095*
ACA/PPHF	$32,358	$82,000	$70,000	+$37,642
Total	**$440,709**	**$490,370**	**$493,616**	**+$52,907**
FTEs	798	835	857	+59

SUMMARY OF THE REQUEST

CDC's FY 2012 request of $493,616,000 for public health scientific services (PHSS), including $70,000,000 from the Affordable Care Act Prevention and Public Health Fund, reflects an overall increase of $52,907,000 above the FY 2010 level. The FY 2012 request includes a reduction of $11,558,000 for CDC's genomics program and an increase of $23,200,000 over the FY 2010 level for health statistics. The FY 2012 request dedicates $5,000,000 within existing PHS Evaluation resources for activities authorized under Section 4301 of the Affordable Care Act.

The FY 2012 request includes $161,883,000 from PHS Evaluation resources to fully fund the National Center for Health Statistics surveys. Funds will increase sample sizes for some surveys and purchase data needed for public health purposes currently collected from vital registration jurisdictions and collection of 12 months of these data within the calendar year. The FY 2012 request includes funding to fully support electronic birth records in all 50 states.

In FY 2012, PHSS funds will support scientific service, expertise, skills, and tools within CDC and with external stakeholders in support of the Agency's efforts to promote health; prevent disease, injury and disability; and prepare for emerging health threats. PHSS leads the development, adoption, and integration of sound public health surveillance and epidemiological practices at CDC based on advances in health statistics, epidemiology, informatics, laboratory science, scientific education and professional development and genomics. Investment in these areas at the local, state and national levels is essential to creating a public health system in which limited resources can be used most effectively; targeted interventions can be applied to those most in need; and, public health programs can be designed to identify the health, health risks, and health problems within and among populations.

AUTHORIZING LEGISLATION

General Authorities*: PHSA §§ 301, 304, 307, 317, 319, 1102

Specific Authorities: PHSA §§ 241, 306, 308, 317G, 318, 319A, 353, 391, 399V, 778, 2315, 2341, 2521; P.L. 107-347, Title V (44 USC 3501 note); Intelligence Reform and Terrorism Prevention Act of 2004 § 7211 (P.L. 108-458); Food, Conservation, And Energy Act of 2008 § 4403 (7 USC 5311a); P.L. 101-445 § 5341 (7 USC 5341); The Affordable Care Act of 2010 (P.L. 111-148)

* See Exhibits tab for a complete list of CDC/ATSDR General Authorities

FY 2012 Authorization……...……...Expired/Indefinite

Allocation Method: Direct Federal/Intramural; Competitive Grants/Cooperative Agreements; Contracts

FUNDING HISTORY

Fiscal Year	Amount*
FY 2007	N/A
FY 2008	N/A
FY 2009	N/A
FY 2010*	$440,709,000
FY 2011CR	$490,370,000

*Funding levels prior to FY 2010 have not been made comparable to the FY 2012 budget realignment.

BUDGET REQUEST

Health Statistics

CDC's FY 2012 request of $161,883,000 for Health Statistics reflects an increase of $23,200,000 above the FY 2010 level. As one of the designated Federal Statistics Agencies and the principal health statistics agency, the National Center for Health Statistics (NCHS) supports the evaluation of HHS' policies and programs through collection of data on births and deaths, health status and health care. Funds will be used to increase sample sizes for some surveys and to purchase data needed for public health purposes currently collected from vital registration jurisdictions and collection of 12 months of these data within the calendar year. The FY 2012 request includes funding to fully support electronic birth records in all 50 states.

In FY 2012, CDC will:

- Continue to support surveys and data collection systems, which provide critical data that represent the society's health in various areas, by:
    - Conducting the National Health Interview Survey (NHIS). The NHIS provides information annually on the health status and health care utilization of the U.S. civilian, non-institutionalized population through confidential household interviews. The NHIS is the core of HHS' data collection and is the nation's largest household health survey providing data for the analysis of a broad range of health and health care topics across racial and ethnic populations.
    - Conducting the National Health Care Surveys, a family of nationally representative health care surveys providing objective, reliable information obtained from providers in physician offices and community health centers, hospital outpatient and emergency departments, and other settings such as long term care facilities and hospitals, about the organizations and providers that supply health care, the services rendered, and the patients they serve.
    - Collecting at least a full 12 months of all public health information on births and deaths from the 57 vital registration jurisdictions (all 50 states, two cities (D.C. and New York), and five territories) through the National Vital Statistics System (NVSS) to provide the nation's official statistics. This information is needed for critical public health purposes. The NVSS provides the most complete and continuous data available to public health officials at the national, state and local levels, and to the private sector.

  - Conducting the National Health and Nutrition Examination Survey (NHANES) on a nationally representative sample of 5,000 individuals at 15 U.S. sites. NHANES is the only national source of objectively measured health data capable of providing accurate estimates of both diagnosed and undiagnosed medical conditions in the population. Data are collected using a combination of personal interviews, standardized physical examinations, diagnostic procedures, and lab tests. The program uses Mobile Examination Centers to travel throughout the country to collect this data annually.

- Continue to support data access and dissemination, which provides information to a wide range of users in formats to meet their needs by:
  - Improving data access and dissemination by ensuring data are available in more easily accessible forms through published reports (print and website), pre-tabulated tables with national and state-level data, and interactive data warehouses.
  - Providing detailed charts and tables on health status and its determinants, health care resources, health care utilization, and health insurance and expenditures through publication of Health, United States.
  - Providing mechanisms for researchers to access the full range of data collected by NCHS, while protecting the confidentiality of the respondents and records through the Research Data Center.
- Continue to support data collection methodology research and dissemination in order to provide accurate data in a timely fashion to meet increasing data requirements by:
  - Improving data collection methodologies by developing a range of methods to evaluate and improve question quality through the Questionnaire Design Research Laboratory.
  - Measuring the impact and implications of cell phone use on telephone surveys and identify differences between wireless-only households (or with no telephone service) and other households.

Performance: The success of CDC's health statistics activities has been demonstrated by the ability to meet various performance measures. The following indicators help the program measure its ability to provide data that is useful, timely and of high quality:

- Producing data on the Internet in easily accessible forms improves the speed and efficiency with which people access the information. CDC has met its goal of developing at least five new tools, technologies, or web enhancements per year from FY 2003 through FY 2010 and has exceeded the goal for the number of visits to the website. (Measure 8.A.1.3b)
- Assessing the satisfaction of key data users and policy makers drives program improvements. In 2010, CDC conducted a series of informational interviews with Federal Power Users to assess their satisfaction with CDC products and services including data quality, ease of data accessibility and use, professionalism of staff, relevance of data to major health issues, and relevance of data to user needs. The target of 100 percent Good or Excellent was met. (Measure 8.A.1.1b)

Program Description and Recent Accomplishments: CDC's Health Statistics program is a unique resource for health information and plays a critical role in documenting public health challenges, supporting epidemiologic and biomedical research, and developing health policy. Data from NCHS systems and surveys are used to track changes in health and health care, including CDC, HHS and Healthy People 2010 goals, and help ensure that program interventions achieve the greatest health impact. Furthermore, these data are readily accessible, via the internet, to policymakers, researchers, private industry and the

public to inform stakeholders on health issues including health reform priorities. Funds are distributed through contracts, interagency agreements and cooperative agreements.

Recent accomplishments include:

- Provided data, through the National Health Care Surveys, on the use of electronic medical records (EMR)/electronic health records (EHR) among office-based physicians. Combined data from the 2009 surveys (mail and in-person surveys) showed that 48.3 percent of physicians reported using all or partial EMR/EHR systems in their office-based practices; about 21.8 percent of physicians reported having systems that met the criteria of a basic system; and about 6.9 percent reported having systems that met the criteria of a fully functional system, a subset of a basic system. Comparing preliminary estimates for 2010 (based on mail survey data only) with these 2009 estimates, the percentage of physicians reporting having systems that met the criteria of a basic or fully functional system increased by 14.2 percent and 46.4 percent respectively.
- Provided the first analysis of state variations in teen birth rates by race and Hispanic origin this year from the National Vital Statistics System. The analysis showed that: 1) the highest rates for non-Hispanic black teenagers were reported in the upper Midwest and in the Southeast, 2) rates for non-Hispanic white and Hispanic teenagers were uniformly higher in the Southeast and lower in the Northeast and California, and 3) the state variation in overall teen birth rates is due to variation in both race and Hispanic origin-specific birth rates and in the population composition for each state.
- Demonstrated, through data from the National Health and Nutrition Examination Survey, the percentage of obese Americans at greater risk of a variety of health problems. In addition, NHANES recently published data on obesity and socioeconomic status in adults, children and adolescents. Results show that: among men, obesity prevalence is generally similar at all income levels, however, higher income non-Hispanic black and Mexican American men are more likely to be obese than low-income men; higher income women are less likely to be obese than low-income women, but most obese women are not low-income; low-income children and adolescents are more likely to be obese than their higher income counterparts, but the relation is not consistent across race and ethnicity groups; and between 1988-1994 and 2007-2008 the prevalence of childhood obesity increased at all income levels and education levels.

Surveillance, Epidemiology, Informatics, and Laboratory Science

CDC's FY 2012 request of $213,794,000, including budget authority and PHS Evaluation transfer funds, for Surveillance, Epidemiology, Informatics, and Laboratory Science is a decrease of $18,054,000 below the FY 2010 level for administrative savings. The FY 2012 request also reflects a significant reduction to the genomics budget. An additional $35,000,000 will be provided from the Affordable Care Act Prevention and Public Health Fund for Healthcare Statistics. CDC's FY 2012 request also includes $15,000,000 for Community Preventive Services Task Force/Community Guide, of which $10,000,000 is from the Affordable Care Act Prevention and Public Health Fund. A description of these activities can be found in the Affordable Care Act Prevention and Public Health Fund section below.

CDC's Surveillance, Epidemiology, Informatics, and Laboratory Science activities strengthen and support the detection, alerting, response, monitoring and analysis of key public health information, which is translated and shared among public health entities across the United States.

Behavioral Risk Factor Surveillance System

CDC's FY 2012 request of $15,190,000 for the Behavioral Risk Factor Surveillance System (BRFSS) is a decrease of $148,000 below the FY 2010 level for administrative savings. BRFSS is a state-based system of health surveys that collects information on health risk behaviors, preventive health practices, and health care access primarily related to chronic disease and injury. Prior to FY 2012, funding for this activity was provided through the Chronic Disease and Health Promotion budget.

In FY 2012, CDC will:

- Move from random digit dialing (RDD) Telephone Format to Mixed Mode Survey Protocols by increasing the proportion of completed cell phone interviews to an appropriate representation relative to cell phone coverage within each state.
- Use information gathered from an initial pilot of mail follow-up surveys to institutionalize the use of mail surveys in all 50 states and territories. This will allow surveys to reach non-respondents of the landline telephone survey.
- Develop an integrated small area estimation system that will allow the production of survey risk factor and health condition estimates for a more comprehensive area than those available in the Selected Metropolitan/Micropolitan Area Risk Trends from the Behavioral Risk Factor Surveillance System (SMART BRFSS).
- Leverage existing mental health surveillance data and establish a CDC-wide mental health surveillance group.

Performance: In FY 2010, CDC funded all 50 states, the District of Columbia (DC), Puerto Rico, the Virgin Islands, Guam, and Palau to conduct surveillance through BRFSS whose data is used by all levels of public health to identify emerging health problems, establish and track health objectives, and develop and evaluate public health policies and programs. BRFSS was able to meet emergent surveillance needs to monitor behavioral aspects of disparate public health events such as the 2009 H1N1 pandemic and mental health effects associated with the Deepwater Horizon oil spill emergency.

Program Description and Recent Accomplishments: CDC's Behavioral Risk Factor Surveillance System, established in 1984, is a state-based system of health surveys that collects information on health risk behaviors, preventive health practices, and health care access primarily related to chronic disease and injury. It is the largest continuously conducted telephone survey in the world, with more than 400,000 interviews annually. States are funded through cooperative agreements to collect ongoing information on behaviors that place health at risk, medical conditions, access to health care, and use of health care services. For many states, it is the only available source of timely, accurate data on health-related behaviors. A wide range of public health officials, researchers, and key decision makers at all levels rely on BRFSS data, which are a critical part of the public health response to local, state and national health problems.

CDC will continue to design and conduct innovative pilot studies to advance the current BRFSS methodology, provide a foundation for the implementation of future methodologies (i.e., use of cell phone and address-based sampling and multilingual surveillance), and maintain this increasingly complex surveillance system that serves the needs of multiple programs while adapting to changes in communications technology, societal behaviors, and population diversity.

Recent accomplishments include:

- Provided 2009/2010 H1N1 vaccination coverage estimates and racial/ethnic differences for key target groups (high-risk adults, health care personnel, pregnant women). State-specific data provided by CDC was used by states to evaluate their progress towards achieving 2009/2010 H1N1 vaccination objectives and to design targeted communications campaigns regarding availability of the vaccine. Data from the BRFSS was used by state health officials to compare local and city health districts' H1N1 vaccination rates to estimates of nationwide and regional H1N1 vaccination rates.
- Provided rapid response to the Deepwater Horizon oil-spill emergency through the implementation of a stand-alone BRFSS-like survey to monitor the mental and behavioral health variables in the adult population in Gulf coast counties affected by the Gulf oil spill. The survey includes questions taken from the ongoing BRFSS as well as additional questions from standardized, validated instruments designed to measure anxiety, depression, and potential stress-associated physical health effects.
- Collected over 400,000 completed BRFSS interviews which provided necessary sample size for the derivation of local level estimates of the prevalence of behavioral risk factors for 283 metropolitan/micropolitan statistical areas. Resultant state and local level data were made publicly available for use by public health stakeholders, agencies, researchers, and the media.

Other Surveillance Activities

CDC's Public Health Surveillance Program assures that timely, accurate and reliable public heath surveillance information is integrated and accessible for decision making. Because of their cross-CDC utility, the BRFSS and several other surveillance systems and activities such as the National Electronic Disease Surveillance System (NEDSS), Biosurveillance Coordination and BioSense are managed within the Public Health Surveillance Program. This allows for leveraging of data sources expertise and new opportunities from increasing automation of healthcare records.

Biosurveillance Coordination and BioSense are funded through the Public Health Preparedness and Response (PHPR) budget line. A description of these programs, their activities and accomplishments is included within the PHPR narrative. NEDSS is funded through the PHSS budget line.

In FY 2012 CDC will:

- Provide leadership in the adoption of standards-based interoperable systems, which are critical for an efficient national strategy.
- Provide resources to state and local health departments for required personnel, training and equipment.
- Use electronic laboratory reporting (ELR) infrastructure to integrate public health laboratory and epidemiologic investigations.

Performance: CDC's work in public health surveillance focuses on establishing public health networks at the state, local and regional levels that have the capability to measure the burden of disease; identify populations at high-risk; identify new or emerging health concerns; monitor trends in the burden of diseases; provide a basis for epidemiologic research; and serve as a guide to the planning, implementation, and evaluation of programs to prevent and control disease, injury or death at the state and local level.

NEDSS continues to make progress in assisting public health reporting jurisdictions (i.e, states, D.C., territories, large metropolitan areas) to share information for routine surveillance and outbreak response.

Publication of case notification message specifications enables public health reporting jurisdictions to generate messages using a common set of standards and specifications. By December 2010, there were four case notification message specifications published. Guides were available for tuberculosis (TB), varicella, arboviral conditions, and generic conditions. Currently, 53 of 60 TB reporting jurisdictions are in production with the TB case notification message (increased from five in 2009); 26 of 40 for the varicella case notification message; five for the generic message; and, one state in production for the arboviral message.

Program Description and Recent Accomplishments: CDC's Public Health Surveillance Program advances the science and practice of surveillance by managing various surveillance systems with cross-CDC utility and developing new information sources, analytic methods, and tools for addressing common and emerging public health challenges while contributing to emergency preparedness and response. The program aims to provide an essential service to CDC programs and health departments that rely on data from surveillance systems and serve as a focal point for answering common questions on addressing challenges in coordinating surveillance.

NEDSS improves the nation's ability to identify, monitor, and investigate diseases and conditions of public health importance, by enabling public health agencies to use information technology more effectively. NEDSS works by: 1) providing leadership in the adoption of standards-based interoperable systems, which are critical for an efficient national strategy; 2) developing and supporting key tools for collecting, exchanging and analyzing information; 3) providing resources to state and local health departments for the required personnel, training and equipment; and 4) using electronic laboratory reporting (ELR) infrastructure to integrate public health laboratory and epidemiologic investigations.

CDC has deployed the NEDSS Base System (NBS) application in 16 states. NBS is an integrated electronic disease surveillance system, which has the capability to receive standards-based ELR. Two states and one jurisdiction are expected to go in to production in FY 2011. The NBS provides public health jurisdictions with a reference implementation of NEDSS policy and standards.

Epidemiology

CDC's efforts within the Epidemiology and Analysis Program Office ensure the targeted application of public health sciences to improve population health through research, methods development, consultation, practice, training, education, and technical assistance. The office focuses on several critical areas including contributing to Health through Prevention by providing expertise in the development of scientific content for the Guide for Community Preventive Services; disseminating timely, useful health information; and, developing innovative methods for the collection, analysis and communication of public health surveillance information.

In FY 2012, CDC will:

- Increase the number of Guide to Community Preventive Services (Community Guide) systematic reviews from an average of six per year to 15 per year. The reviews will strengthen the evidence base and practice of prevention and contribute to health improvements through improved knowledge and informed decision making about what works in preventing disease, disability, injury and death.
- Extend the reach of the Morbidity and Mortality Weekly Report (MMWR), CDC's premier scientific publication, by building bridges to partners and constituents in state and local health departments; enhancing global partnerships with colleagues overseas; bridging the gap between public health and clinical medicine; and reaching out to colleagues at CDC. The MMWR will expand publications and products, for example, incorporating the Community Guide by linking to their website on podcast scripts and identifying new options for death tables.

- Bring focus to an important public health topic through the CDC Vital Signs Program, a monthly call to action on an important public health topic. CDC fosters collaboration among science, policy and communication experts across the Agency and uses multiple media devices to help public health partners in states and communities better identify and address health problems to improve health in their jurisdiction. Topics include colorectal and breast cancer screening, obesity, alcohol and tobacco use, access to health care, HIV testing, seat belt use, cardiovascular disease, teen pregnancy and infant mortality, healthcare-associated infections, asthma, and food borne disease.
- Inform public health policy development and decision making by enhancing the widely distributed analytic methods capacity currently in existence at CDC with expertise in under-represented disciplines such as econometrics, geospatial analysis and advance statistical and mathematical modeling of disease burden and health impact of natural and manmade risks.
- Connect epidemiology and technology to support scientists throughout CDC, across the nation, and around the world with tools for investigating disease outbreaks and adverse health conditions. Epi Info™ Version 7, a suite of software tools planned for release in September 2011, will include enhancements such as flexible data storage, the ability to import data from external sources such as U.S. Census Bureau and NCHS, self contained data analysis capabilities, and the capacity to create questionnaires to improve the speed and accuracy of data collection.
- Develop a National Public Health Library (NPHL), a world class library and information system allowing for advancements in library science and information management directly enhancing CDC's mission. The NPHL will be based on a state-of-the-art IT infrastructure allowing for streamlined information retrieval and improved access to a broader array of materials such as grey literature and other information repositories. Together with the National Library of Medicine, CDC will take advantage of opportunities to improve access to information for state and local health departments, many with little or no access to public health research and literature to inform public health practice.

Performance: This investment allowed CDC to continue as a world leader in the targeted application of public health sciences to improve population health, including epidemiology, geospatial analysis, computer simulation and mathematical modeling, statistical sciences, health economics, and health policy research. CDC ensured the application of these sciences through consultation, practice, training, education, and the provision of technical assistance to public health partners at the state and local levels and health care and public health practitioners working internationally. In addition, CDC enhanced the dissemination of scientific and public health information to ensure that partners in public health and health care received information about evidence-based public health practices in a timely manner and had the tools necessary to inform decision-making and improve practice at a population level. (Measure 8.B.2)

Program Description and Recent Accomplishments: CDC's Epidemiology and Analysis Program Office develops innovative methods for the collection, analysis and communication of public health surveillance information; provides expertise in the development of scientific content for the Guide to Community Preventive Services (Community Guide); provides statistical, modeling, epidemiologic, and econometric expertise within CDC and to external partners; supports County Health Rankings–Mobilizing Action Toward Community Health (MATCH); and delivers credible, timely information from public health literature to the CDC community and externally to partners through the CDC Public Health Library and Information Center.

Recent accomplishments include:

- Demonstrated that Community Guide reviews are being used to inform decision-making at the national level. The National President of Mothers Against Drunk Driving cited a recent Community Guide review on the effectiveness of ignition interlocks in reducing recidivism among alcohol-impaired drivers during an April 2010 Senate Environment and Public Works Committee hearing on opportunities to improve transportation safety; and the executive committee of the American Automobile Association (AAA) considered the same review during a March 2010 meeting in which they deliberated about whether AAA should officially endorse the expanded use of ignition interlocks.
- Launched CDC Vital Signs in July 2010, publishing a total of three issues during the fiscal year. Each issue received considerable media attention, which facilitated nationwide distribution of the information to key stakeholder groups. CDC also collaborated with the Robert Wood Johnson Foundation to release the first annual County Health Rankings, which ranked the population health of every county of each state in the United States, and provided over 50 percent of the health data and indicators used to determine the rankings.

Informatics

CDC's work in the area of public health informatics and technology supports health and public health practice by advancing better management and use of information and knowledge. The goals of the Public Health Informatics and Technology Program Office are to maximize prevention using health information technology and health information exchange; increase the effectiveness and efficiency of public health agencies by improving their capacity to manage information and knowledge; and, advance and share new knowledge in public health informatics

In FY 2012, CDC will:

- Maximize prevention using Health Information Technology and Health Information Exchange (HITECH) to support outcomes such as improved immunization rates and chronic disease management.
- Increase public health's capability to manage information for more effective and efficient programs, through informatics planning, consultation and technical assistance; standards development and promotion; and services shared by multiple health information systems.
- Advance and share knowledge about how information technology can improve health outcomes.

Performance: One key to better effectiveness and efficiency is that critical information can move between information systems ("interoperability") to be available when and where needed. This requires standardization of data and systems. In FY 2010, 28 states (18 above target) transmitted electronic disease reports according to national standards. (Measure 8.B.1.1) This movement toward interoperable public health systems will be further accelerated by the HITECH Act. CDC worked closely with the Office of the National Coordinator for HIT and CMS to ensure that medicine and public health both use new Federal standards to improve the prevention and management of communicable diseases, chronic disease, disability and injury. For example, CDC funded and provided technical support to 10 state and local jurisdictions to receive electronic lab reports about communicable diseases and 20 jurisdictions to import immunization records from electronic health records (using HITECH funding).

Program Description and Recent Accomplishments: CDC's Informatics Program uses information science and technology to improve the effectiveness and efficiency of programs to prevent disease, disability and death. This is accomplished through the use of electronic information systems to get critical information to those making health decisions or taking action to protect lives. CDC develops policies and

standards for information exchange between healthcare providers, public health agencies and emergency response officials. The Program provides funding and technical support to information management systems across several National Centers and operates critical alerting, messaging, directory, storage and routing systems used across the nation's public health system. The Informatics Program uses regional health information exchanges for surveillance and communication and works with electronic health record systems to provide prevention-oriented decision support for doctors and nurses while they treat patients. The Program also advances the knowledge of public health informatics via cooperative agreements with several university Centers of Excellence and provides information on best practices to the local, state, Federal and global public health workforce via distance learning, publications and conferences.

Recent accomplishments include:

- Received real-time H1N1 influenza intelligence from three multi-state health information exchanges and automated reporting of communicable disease information from Ohio and Utah health systems to public health authorities by CDC-supported systems.
- Improved efficiency in information management including a 50 percent time reduction for the validation of standardized messages and nearly halving contractor labor needs through data warehouse consolidation.
- Certified 43 Public Health Emergency Preparedness Cooperative Agreement awardees for their capability to securely exchange information across jurisdictions (federal, state, territorial, tribal, and local) and to quickly identify health threats, analyze data, communicate alerts, and track the results of public health actions.

Laboratory Science

CDC's Laboratory Science Policy and Practice Program Office provides leadership, coordination, and services to strengthen laboratory science, policy and practice in order to improve laboratory quality and healthcare outcomes. The efforts of this office target CDC and all levels of the national and global healthcare systems.

In FY 2012, CDC will:

- Continue newly planned laboratory informatics activities from FY 2011, including working with internal and external partners to improve electronic transfer and sharing of laboratory data and interoperability of systems.
- Create laboratory-specific training modules for national and international audiences as part of CDC's overall e-learning effort.
- Conduct and evaluate preparedness/response laboratory trainings given by CDC's National Laboratory Training Network (NLTN).
- Develop a plan to maximize cost-benefit and assure scientific integrity for CDC's collection of historical and scientifically valuable biological specimens, known as the CDC and ATSDR Specimen Packaging, Inventory and Repository (CASPIR).
- Manage CDC's Select Agents/Toxins Compliance program and ensure adherence to established security plan and training requirements, biosecurity plan precautions, and maintenance of required secure inventory records in all CDC laboratories.

- Extend the reach and use of CDC's Technology Transfer program by educating CDC scientists, about the importance of making valuable government inventions available to a wide range of users. Increase the number of these inventions that are transferred to the private sector for broader use.

Performance: The newly formed Laboratory Science, Policy, and Practice Program Office brings together several groups from across CDC that have worked extensively to improve laboratory quality and practices. In addition, it creates new and expanded programs targeted on the same goal. The development of quality laboratory standards, both voluntary and regulatory (e.g. CLIA), has made important contributions to the improvement of laboratory practice in the United States. Extensive training for laboratorians has covered a wide range of topics all aimed at improved performance of laboratories. Other efforts have contributed to internal CDC laboratories to ensure that quality and safety practices are followed.

Program Description and Recent Accomplishments: CDC's Laboratory Science Policy and Practice Program Office provides leadership, policy development, technical expertise, and training in quality management systems and practices, and works with public health and private health care partners in improving laboratory practice both nationally and globally. The program conducts practice research on laboratory best practices and develops guidelines and standards to assist laboratories in improving performance. In addition, the program provides direct assistance to CDC laboratories by providing specimen management and repository support, conducting the Select Agent Compliance Program, and managing and stimulating technology transfer.

Recent accomplishments include:

- Reported, through the first nine months of FY 2010, that 70 percent of public health and clinical laboratorians attending biosecurity and biosafety NLTN courses would add these new practices or modify their current practices as a result of the training. Reported that 93 percent of the trained professionals are able to successfully transfer the methodology to their LRN Reference Laboratories and make accurate identifications of the biologic threat agents.
- Licensed the CDC-discovered Novel H1N1 Influenza Virus Test to a commercial entity such that laboratories around the world can acquire the H1N1 laboratory test materials for their communities.

Public Health Workforce and Career Development

CDC's FY 2012 request of $47,939,000 for Public Health Workforce and Career Development reflects an increase of $10,119,000 above the FY 2010 level. The increase will support the CDC Prevention Corps training program. CDC's workforce programs help to ensure a prepared, diverse, sustainable public health workforce through experiential fellowships and high-quality training programs, including e-learning. An additional $25,000,000 from the Affordable Care Act Prevention and Public Health Fund will support Public Health Workforce activities. A description of these activities can be found in the Affordable Care Act Prevention and Public Health Fund section below. In FY 2012, CDC will:

- Provide fellowship programs to develop public health skills through service and experiential learning.
- Expand the use of technology to improve access to high-quality public health content for training the health professional workforce.
- Provide instructional design services for innovative e-learning programs and accredit educational activities for continuing education credit for a range of health professions.

- Support the CDC Prevention Corps, a workforce program to recruit and train new talent for assignments in state and local health departments. This new program will also address retention by requiring professional to commit to a designated timeframe in state and local health departments as a condition of the fellowship.

Performance: This investment has allowed CDC to improve public health workforce capabilities for an effective, prepared, and sustainable health workforce to meet emerging public health challenges. Each year, CDC recruits, selects, and trains fellows in critical disciplines of epidemiology, informatics, laboratory, management, prevention effectiveness, preventive medicine, and other emerging areas. These fellows work closely with staff in federal, state and local public health agencies to respond to disease outbreaks and other health threats.

In 2010, CDC achieved the target for Measure 8.B.4.1 with 200 core-funded fellows joining public health programs in local, state, and federal health departments to participate in training in epidemiology or public health leadership management. In 2010, CDC initiated a new measure (Measure 8.B.4.2) to increase the number of CDC trainees in State, Tribal, and Territorial public health agencies and made significant progress with 182 trainees in 2010 in contrast to the 2009 baseline of 119 trainees.

CDC also maintains a Continuing Education (CE) Program which, in 2010, accredited 425 CDC-sponsored offerings and awarded CE credit to physicians, nurses, pharmacists, health educators, veterinarians, and others in over 65,000 course registrations.

Program Description and Recent Accomplishments: CDC's Scientific Education and Professional Development programs ensure the use of best practices for workforce and career-development programs and promote an environment of continuous learning. CDC's fellowship programs provide opportunities to develop public health skills while providing service to state/local health departments and filling critical gaps in key areas such as epidemiology, informatics, prevention effectiveness (health economics and decision sciences), preventive medicine, and management. The fellowships include the Epidemic Intelligence Service (EIS), the Prevention Effectiveness Fellowship Program (PEFP), the Public Health Informatics Fellowship Program, (PHIFP), Preventive Medicine Residency and Fellowship (PMR/F), and the Public Health Prevention Service (PHPS).

CDC's workforce programs operate nationally. Training and continuing education programs leverage use of technology to ensure access to high-quality public health content for all health professionals wherever they are located. Fellows are stationed at CDC or in the field and regardless of where stationed, provide front-line advice and technical assistance in epidemiology, informatics, economics, program management, and policy analysis which strengthens the ability of state and local health departments to respond to public health problems and emergencies and to build connections with the health care system. Funding is currently spent intramurally for salaries and benefits for fellows and program administration. Extramurally, funding is provided through cooperative agreements and contracts to support research, education, academic partnerships, and collaborative activities necessary to meet the program's goal of providing high-quality workforce program.

Recent accomplishments include:

- Responded to 102 requests for epidemiologic assistance from local, state, and international health agencies. EIS officers assigned to state and local health departments conducted over 225 epidemic investigations in their assignment locations.
- Responded to 13 requests from health departments for informatics assistance from PHIFP fellows to develop, evaluate, and implement strategies to manage information systems effectively and efficiently.

- Launched the Learning Connection website to maximize use of technology for access to quality public health learning products for health professionals.

Public Health Genomics

CDC's FY 2012 request of $749,000 for Genomics reflects a decrease of $11,558,000 below the FY 2010 level. CDC recognizes overlap in this area with other Federal agencies and will focus the remaining resources on the implementation of proven applications of genomics to areas of public health importance. In FY 2012, CDC will maintain a core staff to advise CDC leadership, programs and public health partners on emerging genomic applications and issues relevant to public health; helping to ensure that CDC is able to continue to contribute to the public discourse regarding the population health perspective on emerging genomic applications and issues, and that CDC leadership remains aware of genomic applications and issues with the potential to impact public health. Funds could also support convening internal and external stakeholders to identify public health opportunities in genomics.

Performance: Through investment in public health genomics, CDC has provided leadership in identifying and implementing evidence-based practices for genetic tests and family health history tools to improve health and prevent harms through valid and useful genomics clinical and public health practices. CDC's Public Health Genomics program has also expanded the knowledge base supporting evidence-based practices for genetic tests and family health history tools, through the development and dissemination of new EGAPP-sponsored evidence-based reviews and recommendations. (Output 8.C) In FY 2010, CDC funded four cooperative agreements, including two state health departments, to conduct genomics surveillance, education or policy to implement and evaluate evidence-based practices for genetic tests and family health history tools to improve health outcomes. (Output 8.B)

Program Description and Recent Accomplishments: Genomics plays a part in nine of the ten leading causes of death in the United States, including heart disease, cancer, stroke, chronic lower respiratory diseases, diabetes, and Alzheimer's 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. CDC's Office of Public Health Genomics, established in 1997, will continue to provide public health genomics expertise across the agency and inform agency leadership on genomic applications and issues relevant to CDC's mission; identify and assess genomic applications with the potential for population health impact; and provide public health science expertise to and work with CDC programs, other agencies, and external partners to facilitate the implementation of genomic applications with potential to improve population health.

Recent accomplishments include:

- Funded the Michigan Department of Community Health to increase the number of health plans that have policies consistent with U.S. Preventive Services Task Force recommendations for genetic risk assessment for hereditary breast and ovarian cancer. The number of health plans in Michigan increased from four to nine out of 24, which extended coverage to over 6.3 million Michigan residents.
- Launched the Genomic Applications in Practice and Prevention Knowledge Base (GAPP-KB), an online, centralized resource for information on the validity and utility of genomic applications, including genetic tests and family history, for use in public health and health care. GAPP-KB features the GAPP Finder, a continuously updated, searchable database of genetic tests in transition to practice; PloS Currents Evidence on Genomic Tests, an online, open-access journal for publishing knowledge summaries; and links to published evidence reviews and recommendations.

- Published an analysis of NHANES data finding that incorporating family health history with traditional diabetes risk factors could identify an additional 620,000 individuals in the U.S. population with undiagnosed diabetes without a significant change in the false positive fraction.

IT INVESTMENTS

Due to investments in health information technology (Health IT), CDC's Public Health Scientific Services program can more rapidly and efficiently collect, monitor, analyze, respond to and disseminate public health information. These investments have developed and continue to support the detection and management of secure epidemiologic surveillance and laboratory science standard vocabularies, message formats, infrastructure, and systems. Investments in Health IT support multiple programs within CDC, and state, local and tribal health departments across the country. Health IT investments create the framework and systems necessary to monitor and track outbreaks, epidemics, and pandemics, such as 2009 H1N1 pandemic influenza, for case counts, distribution and geospatial visualization in near real-time. These investments lay the groundwork for building interoperability between state, local and tribal health jurisdictions and the CDC, as well as between and across the health jurisdictions themselves.

IT investments include BioSense, which is an emergency preparedness system to detect disease and provide near real-time situational awareness to all levels of public health, the National Electronic Disease Surveillance System, which is tying together the current myriad, separate disease surveillance systems into a comprehensive solution that facilitates the efficient collection, analysis, and use of data and the sharing of computer software solutions across disease-specific program areas, and the Archival Specimen Tracking and Retrieval Operations system that is used to assure accurate and timely receipt, tracking, shipping, inventory maintenance and provision of ad hoc reporting of the laboratory specimen collections at CDC. IT investments also include the National Vital Statistics System that collects data from the vital records of states, and then processes, tabulates, analyzes, and disseminates demographic and medical information related to all recorded births and deaths in the United States.

AFFORDABLE CARE ACT PREVENTION AND PUBLIC HEALTH FUND

The following activities are included:

- Healthcare Statistics/Surveillance – $35,000,000
- Public Health Workforce – $25,000,000
- Community Preventive Services Task Force/ Community Guide – $10,000,000

Healthcare Statistics/Surveillance

The National Health Interview Survey (NHIS), National Ambulatory Medical Care Survey (NAMCS) and National Hospital Ambulatory Medical Care Survey (NHAMCS) are the core data systems used to monitor the effects of the Affordable Care Act.

The NHIS will include questions to track the ACA impact on access and utilization of care. The impact on health and health care disparities, including utilization of services such as screening tests and diagnostic and therapeutic procedures, will also be monitored. The increase in the NHIS sample will provide stable estimates for targeted populations. The NAMCS sample of physicians in offices will be expanding to permit greater precision for estimates related to care received for different population groups and with different conditions. Collectively, these monitoring efforts will illustrate the impact of improved access to care on prevention of illness, control of acute episodes, management of chronic conditions, and ultimately health outcomes.

Surveys of ambulatory care through the National Ambulatory Medical Care Survey and to hospital outpatient departments through the National Hospital Ambulatory Medical Care Survey will be expanding

the data collected on clinical management and on patient's risk factors for those with heart disease and stroke during the 12 months before the sampled visit. Along with data already collected on intermediate outcomes, these data and resulting analysis will permit monitoring and evaluating goals to increase prevention through health care programs and expanded insurance coverage.

Funding in FY 2012 will also be used to fund the BRFSS to track the impact of the ACA on access to and utilization of health care resources and to evaluate the impact of ACA on prevalence estimates for diseases, health conditions, and risk behaviors for the leading causes of death and disability. The requested funds would cover the cost to: (1) add approximately six questions to the BRFSS yearly cycle to address components of the ACA as they are implemented, (2) apply small area estimation to produce estimates for all U.S. counties, and (3) increase population coverage of the BRFSS by expanding multimode protocol implementation to reach populations currently underrepresented in the landline BRFSS and to produce estimates at state level. The new data in combination with the other information routinely collected by the survey will help establish a timely baseline for the initial ACA provisions and assist in evaluating the effects on a yearly basis. FY 2012 funds will be used to develop, program, and implement this data collection in calendar year 2013.

Public Health Workforce

This investment aims to increase the number and types of competency trained public health professionals and place them in areas of great need, such as state and local health agencies. Funds will be used to develop the capacity of the public health workforce in critical fellowships and other training and education programs; ensure access to high-quality public health learning resources, including e-learning; and increase short-term technical assistance to state and local health agencies in epidemiology, informatics, economics, and policy analysis. This activity will support section 5314, "Fellowship training in public health" of the ACA.

Community Preventive Services Task Force/ Community Guide

The Task Force/Community Guide will focus on working with official Liaison Organizations to the Task Force on the dissemination, adoption, and utilization of Task Force recommendations and findings to inform decision making to improve health through the use of evidence-based interventions. There are more than 28 official Liaison Organizations to the Task Force, which represent various federal agencies, non-governmental organizations, and professional agencies. Dissemination efforts would target agencies and organizations that are working to provide assistance to decision makers in dissemination, adoption, and implementation of Community Guide recommendations in their communities. These Liaison Organizations would work directly with State and Local Health Departments with the intent to begin expanding these activities to Territorial and Tribal health organizations as additional funds are available.

The Task Force/Community Guide will enhance dissemination, adoption and utilization of Task Force recommendations and findings to inform decision making to improve health thorough the use of evidence-based interventions beyond the 28 Official Liaison Organizations, through engagement with the Department of Energy (DOE)/Oak Ridge Institute for Science and Education, CDC Foundation, National Commission on Prevention Priorities (NCPP), Public Health Foundation (PHF), National Public Health Information Coalition (NPHIC), Evidence-Based Practice Centers (EPCs), and Agency for Health Research and Quality (AHRQ). Direct support would also be provided to state and local health departments for targeted dissemination efforts.

PROGRAM ACTIVITIES TABLE

(dollars in thousands)	FY 2010 Enacted	FY 2011 Continuing Resolution	FY 2012 President's Budget	FY 2012 +/- FY 2010
Public Health Scientific Support	**$440,709**	**$490,370**	**$493,616**	**+$52,907**
- Health Statistics	$158,541	$168,683	$196,883	+$38,342
- ACA/PPHF (non-add)	$19,858	30,000	$35,000	+$15,142
- Offices of Surveillance, Epidemiology, and Public Health Informatics	$236,848	$258,861	$223,794	-$13,054
- ACA/PPHF (non-add)	$5,000	$27,000	$10,000	+$5,000
- Public Health Workforce and Career Development	$45,320	$62,826	$72,939	+$27,619
- ACA/PPHF (non-add)	$7,500	$25,000	$25,000	+$17,500

MEASURES TABLE[1]

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
Health Statistics				
Long Term Objective 8.A.1: Monitor trends in the nation's health through high-quality data systems and deliver timely data to the nation's health decision-makers.				
8.A.E.1: The number of months for release of data as measured by the time from end of data collection to data release on internet	FY 2007: 10.8 (Target Unmet)	9.6 months	9.4 months	- 0.2 months
8.A.1.1a: Percentage of key data users and policy makers, including reimbursable collaborators that are satisfied with data quality and relevance: web survey (Outcome)	FY 2010: 71.3% (Target Not Met but Improved)	Increase satisfied from 67.2% to 72.2% (agree or strongly agree)	Maintain 75.2%	N/A
8.A.1.1b: Percentage of key data users and policy makers, including reimbursable collaborators that are satisfied with data quality and relevance: federal power users (Outcome)	FY 2010: 100% Good or Excellent (Target Met) (Target Met)	Maintain 100% Satisfaction	Maintain 100% Good or Excellent	N/A
8.A.1.1c: Percentage of key data users and policy makers, including reimbursable collaborators that are satisfied with data quality and relevance: reimbursable customers (Outcome) [2]	FY 2007: 91% (35% good, 56% Excellent) (Baseline)	N/A	N/A: will not be conducted again until 2016	N/A
8.A.1.1d: Percentage of key data users and policy makers, including reimbursable collaborators that are satisfied with data quality and relevance: data users conference attendees (Outcome)	FY 2007: 91% (53% Good, 38% Excellent) (Baseline)	Conduct survey/increase Excellent from 38% to 43%	Increase Excellent from 43% to 45%	N/A
8.A.1.2: The number of new or revised charts and tables and methodological changes in Health, United States, as a proxy for continuous improvement and innovation in the scope and detail of information. (Output)	FY 2009: 23 (Target Exceeded)	15	20	+5
8.A.1.3a: Number of improved user tools and technologies and web visits as a proxy for the use of NCHS data: Number of improved user tools and technologies (Output)	FY 2010: 7 (Target Exceeded)	5	5	Maintain
8.A.1.3b: Number of improved user tools and technologies and web visits as a proxy for the use of NCHS data: Number of web visits (Output)	FY 2010: 8.7 million (Target Exceeded)	7.5 million	8.5 million	+1.0 million

Surveillance, Epidemiology, and Laboratory Services				
Long Term Objective 8.B.1: Lower barriers to data exchange across jurisdictions for public health surveillance and response.				
8.B.1.1: Increase the number of States that can send electronic messages to CDC in compliance with published standards (Output)	FY 2010: 28 states (Target Exceeded)	10 states	42 states	+32 states
Long Term Objective 8.B.2: Improve access to and reach CDC's scientific health information among key audiences to maximize health impact				
8.B.2.1: Provide health information to health professionals and partner organizations (e.g. state and local health departments) in order to educate, inform and improve health outcomes (system approaches to health) a. Number of subscribers to the Morbidity and Mortality Weekly Report (MMWR) (Outcome)	FY 2010: 130,357 (Target Exceeded)	130,322	135,322	+5,000
8.B.2.2: Increase the electronic media reach of CDC Vital Signs through the use of mechanisms such as CDC.gov and social media outlets (Output)	FY 2010: 256,243 (Historical Actual)	N/A	420,000	N/A
8.B.2.3: Increase the number of annual Community Guide reviews (Output)	FY 2010: 18 (Target Exceeded)	9	15	+6
8.B.2.4: Increase the number of counties/communities that implement evidence-based policies/interventions as a result of their county health ranking (MATCH County Rankings program) (Intermediate Outcome)	FY 2010: 5 (Baseline)	N/A	20	N/A

Long Term Objective 8.B.3: 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.				
8.B.3.1: Evaluate the impact of training programs conducted by the NLTN on laboratory practices (Outcome)	FY 2010: 70% (Target Met)	More than 65% of public health and clinical laboratorians attending biosecurity and biosafety NLTN courses who reported lacking practices for protection of individuals, security of assets and information, or training/practice drills added these practices or modified current practices as a result of the course.	More than 50% of public health and clinical laboratorians attending NLTN public health laboratory workshops either updated or improved laboratory policies or practices as a result of the course.	N/A
Scientific and Educational Development				
Long Term Objective 8.B.4: CDC will develop and implement training to provide for an effective, prepared, and sustainable health workforce able to meet emerging health challenges.				
8.B.4.1: Maintain the number of recruits who join public health programs in local, state, and federal health departments to participate in training in epidemiology or public health leadership management (Output)	FY 2010: 200 (Target Met)	200	200	Maintain
8.B.4.2: Increase the number of CDC trainees in State, Tribal, Local, and Territorial public health agencies (Output)	FY 2010: 182 (Historical Actual)	N/A	237	N/A

[1]Some targets reflect impact of funding from ACA/PPHF
[2]2010 results will not be available until December 2011

OUTPUT TABLE[1]

Other Outputs	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
8.A: States and territories funded for conducting surveillance	FY 2009: 55	55	55	Maintain
8.B: States funded to implement and evaluate genomics interventions	FY 2010: 2	2	0	-2
8.C: EGAPP-sponsored evidence reviews or recommendation statements published	FY 2009: 6	6	0	-6
8.E: Number of key elements of the health care system for which data are collected	FY 2009: 3	3	3	Maintain
8.F: Number of communities visited by mobile examination centers from the National Health and Nutrition Examination Survey	FY 2009: 15	15	15	Maintain
8.G: Number of households interviewed in the National Health Interview Survey[2,3]	FY 2010: 39,000	35,000	46,500	+11,500
8.H: Number of physicians and visit records surveyed in the National Ambulatory Medical Care Survey[3]	FY 2010: 3,662 physicians; 30,600 visit records	3,400 physicians; 30,000 visit records	10,200 physicians; 90,000 patient records	+6,800 physicians; +60,000 visit records
8.I: Number of states funded to provide electronic birth records (either completely or in part)	FY 2009: 0	0	10	+10
8. J: States actively engaged in ongoing NEDSS/PHIN-compatible systems integration	FY 2008: 42 (Target Exceeded)	45	50	+5
8.K: States developing NEDSS-compatible systems, in deployment, or lie with the NEDSS Base System	FY 2009: 50 (Target met)	50	50	Maintain

[1]Some targets reflect impact of funding from ACA/PPHF.
[2]The target was exceeded - there was an increase in sample size during the first quarter of FY 2010 to reinstate a sample cut made in January - March 2009.
[3]The increase in sample size for NHIS and NAMCS will vary depending on when funds are received.

STATE TABLE[1]

FY 2012 DISCRETIONARY STATE/FORMULA GRANTS BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM				
STATE/TERRITORY	**FY 2010 Actual**	**FY 2011 CR**	**FY 2012 Estimate**	**FY 2012 +/- FY 2010**
Alabama	$166,373	$166,373	$166,373	0
Alaska	$317,147	$317,147	$317,147	0
Arizona	$272,871	$272,871	$272,871	0
Arkansas	$289,386	$289,386	$289,386	0
California	$282,621	$282,621	$282,621	0
Colorado	$316,320	$316,320	$316,320	0
Connecticut	$239,377	$239,377	$239,377	0
Delaware	$176,410	$176,410	$176,410	0
District of Columbia	$220,559	$220,559	$220,559	0
Florida	$261,678	$261,678	$261,678	0
Georgia	$148,789	$148,789	$148,789	0
Hawaii	$267,909	$267,909	$267,909	0
Idaho	$321,681	$321,681	$321,681	0
Illinois	$170,431	$170,431	$170,431	0
Indiana	$208,050	$208,050	$208,050	0
Iowa	$202,800	$202,800	$202,800	0
Kansas	$340,356	$340,356	$340,356	0
Kentucky	$220,069	$220,069	$220,069	0
Louisiana	$162,338	$162,338	$162,338	0
Maine	$230,858	$230,858	$230,858	0
Maryland	$263,672	$263,672	$263,672	0
Massachusetts	$269,236	$269,236	$269,236	0
Michigan	$240,043	$240,043	$240,043	0
Minnesota	$253,795	$253,795	$253,795	0
Mississippi	$197,821	$197,821	$197,821	0
Missouri	$196,157	$196,157	$196,157	0
Montana	$272,543	$272,543	$272,543	0
Nebraska	$214,900	$214,900	$214,900	0
Nevada	$297,268	$297,268	$297,268	0
New Hampshire	$236,390	$236,390	$236,390	0
New Jersey	$178,034	$178,034	$178,034	0
New Mexico	$309,716	$309,716	$309,716	0
New York	$248,698	$248,698	$248,698	0
North Carolina	$216,917	$216,917	$216,917	0
North Dakota	$223,679	$223,679	$223,679	0
Ohio	$244,882	$244,882	$244,882	0
Oklahoma	$210,691	$210,691	$210,691	0
Oregon	$306,498	$306,498	$306,498	0
Pennsylvania	$191,276	$191,276	$191,276	0

FY 2012 DISCRETIONARY STATE/FORMULA GRANTS BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM				
STATE/TERRITORY	**FY 2010 Actual**	**FY 2011 CR**	**FY 2012 Estimate**	**FY 2012 +/- FY 2010**
Rhode Island	$185,923	$185,923	$185,923	0
South Carolina	$255,074	$255,074	$255,074	0
South Dakota	$189,170	$189,170	$189,170	0
Tennessee	$198,151	$198,151	$198,151	0
Texas	$260,112	$260,112	$260,112	0
Utah	$288,769	$288,769	$288,769	0
Vermont	$190,707	$190,707	$190,707	0
Virginia	$206,347	$206,347	$206,347	0
Washington	$292,434	$292,434	$292,434	0
West Virginia	$272,646	$272,646	$272,646	0
Wisconsin	$191,367	$191,367	$191,367	0
Wyoming	$306,063	$306,063	$306,063	0
State Sub-Total	**$12,225,002**	**$12,225,002**	**$12,225,002**	**0**
America Samoa	0	0	0	0
Guam	$192,862	$192,862	$192,862	0
Marshall Islands	0	0	0	0
Micronesia	0	0	0	0
Northern Marianas	0	0	0	0
Puerto Rico	$207,602	$207,602	$207,602	0
Palau	$29,530	$29,530	$29,530	0
Virgin Islands	$114,342	$114,342	$114,342	0
Territory Sub-Total	**$544,336**	**$544,336**	**$544,336**	**0**
Total States/Territories	**$12,769,338**	**$12,769,338**	**$12,769,338**	**0**

[1] Table does not include funding from ACA/PPHF.