

**PUBLIC HEALTH SCIENTIFIC SERVICES**

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Budget Authority	\$147.795	\$143.972	\$35.695	-\$108.277
PHS Evaluation Transfer	\$247.769	\$247.769	\$379.374	+\$131.605
ACA/PPHF	\$72.000	\$70.000	\$90.000	+\$20.000
<b>Total</b>	<b>\$467.564</b>	<b>\$461.741</b>	<b>\$505.069</b>	<b>+\$43.328</b>
FTEs	1,114	1,109	1,107	-2

**Authorizing Legislation:** PHS § 241, 301, 304, 306, 307, 308, 317, 317G, 318, 319, 319A, 353, 391, 399V, 778, 1102, 2315, 2341, 2521; P.L. 107-347, Title V (44 U.S.C. 3501 note); Intelligence Reform and Terrorism Prevention Act of 2004 § 7211 (P.L. 108-458); Food, Conservation, And Energy Act of 2008 § 4403 (7 U.S.C. 5311a); P.L. 101-445 § 5341 (7 U.S.C. 5341); The Patient Protection and Affordable Care Act of 2010 (P.L. 111-148)

**FY 2013 Authorization**.....Expired/Indefinite

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

**SUMMARY**

CDC’s FY 2013 request of \$505,069,000 for public health scientific services, including \$90,000,000 from the Affordable Care Act Prevention and Public Health Fund, is an overall increase of \$43,328,000 above the FY 2012 level. The FY 2013 request includes an increase of \$23,150,000 for health statistics and \$20,000,000 for a Laboratory Efficiencies initiative.

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Health Statistics	\$138.683	\$138.683	\$161.833	+\$23.150
Surveillance, Epidemiology, and Public Health Informatics	\$220.747	\$217.129	\$217.541	+\$0.412
Public Health Workforce and Career Development	\$36.134	\$35.929	\$35.695	-\$0.234
ACA/PPHF	\$72.000	\$70.000	\$90.000	+\$20.000
<b>Total</b>	<b>\$467.564</b>	<b>\$461.741</b>	<b>\$505.069</b>	<b>+\$43.328</b>

Our public health system must continue to address health problems in this country. To achieve this goal, CDC:

- Compiles statistical information to inform policies that improve public health.
- Assures accuracy and reliability of laboratory tests.
- Applies digital information technology to help detect and manage diseases, injuries, and syndromes.
- Leads in the development, adoption, and integration of sound public health surveillance, laboratory protocols, and epidemiological practices.
- Uses public health science to improve the population’s health.
- Prepares public health professionals to meet emerging and ongoing public health challenges.

**FUNDING HISTORY**<sup>1</sup>

Fiscal Year	Dollars (in millions)
2008	N/A
2009	N/A
2010	\$408.351
2010 (ACA/PPHF)	\$32.358
2011	\$395.564
2011 (ACA/PPHF)	\$72.000
2012	\$391.741
2012 (ACA/PPHF)	\$70.000

<sup>1</sup>Funding levels prior to FY 2010 have not been made comparable to the budget realignment.

**HEALTH STATISTICS BUDGET REQUEST**

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
<b>PHS Evaluation Transfer</b>	<b>\$138.683</b>	<b>\$138.683</b>	<b>\$161.833</b>	<b>+\$23.150</b>

Program Overview: The National Center for Health Statistics (NCHS) is a designated Federal Statistics Agency and the nation’s principal health statistics agency. CDC collects data on births and deaths, health status, and health care. CDC's health statistics program compiles statistical information to guide actions and policies to improve the health of the nation. NCHS’ data products provide a unique resource for health information and play a critical role in documenting public health challenges, supporting epidemiologic and biomedical research, and informing health policy development.

Recent accomplishments:

- Tracked the progress in adopting electronic medical and health records throughout the nation's health care system to improve the quality and efficiency of health care services.
  - The National Health Care Surveys provide estimates of the adoption of Electronic Health Records (EHR) and EHR Systems among office-based physicians. Preliminary 2011 estimates show the percentage of physicians with a basic system increased by 35.7 percent from 2010 (from 24.9 percent to 33.8 percent). The percentage of physicians with systems that met the criteria of a basic system by state ranged from 15.6 percent (New Jersey) to 60.7 percent (Minnesota).
- Documented trends in the teen birth rate using data from the National Vital Statistics System.
  - Teenage birth rates for each age group and for nearly all race and Hispanic origin groups in 2009 were at the lowest levels ever reported in the United States. The rate overall was 39.1 births per 1,000 women aged 15–19 years.
- Provided current and complete national and state specific data to track health insurance coverage.
  - Demonstrated among adults aged 19–25 years of age—a group targeted by provisions in the Affordable Care Act—that the percentage of uninsured decreased from 33.9 percent (10 million) in 2010 to 28.8 percent (8.7 million) in the first six months of 2011.

Budget Proposal: CDC’s FY 2013 request of \$161,833,000 for health statistics is an increase of \$23,150,000 above the FY 2012 level. The budget maintains CDC’s capacity to fully support its ongoing seminal health and health care surveys, in particular the National Health Interview Survey, National Health and Nutrition Examination Survey and the National Health Care Surveys (NCHS) 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. Of the \$23,150,000 increase, \$16,450,000 will enable CDC to begin to phase in full implementation of the electronic death records in as many jurisdictions as possible (initial target of 15 to 17 states). The \$23,150,000 increase will also support full implementation of new questions on sexual orientation into the full National Health Interview Survey (NHIS) data collection pending the successful conduct of the pretest and the development and implementation of new sample designs for population-based surveys following the 2010 Census, as well as improvements and expansions of data collection methods.

In FY 2013, CDC will:

- Monitor the U.S. population's health, access to, and use of health care services by conducting the NHIS. Pending the completion of a successful field test, new questions will be incorporated on sexual orientation into the full NHIS to support initiatives to reduce disparities in health and health care by sexual orientation in January 2013. NHIS is the nation's largest household interview survey. It provides extensive data on a broad range of health topics and serves as the core of HHS' data collection.
- Conduct the NHCS, a family of nationally representative health care surveys providing objective, reliable information obtained from ambulatory and inpatient care providers, including physician offices, hospitals, and long-term facilities. The NHCS are the only source of comparable data on health care providers, services rendered, and the patients they serve.
- Collect the nation's official statistics for births and deaths through the National Vital Statistics System (NVSS). The NVSS provides the most complete and continuous data available to public health officials at the national, state, and local levels, as well as the private sector.
- Measure diagnosed and undiagnosed medical conditions across the United States. CDC will collect data using personal interviews, physical examinations, diagnostic procedures, and lab tests. The National Health and Nutrition Examination Survey (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.
- Support data access and dissemination by:
  - Making data more easily accessible.
  - Providing health, health care, and health insurance information through Health, United States, the Secretary's report to Congress on the health of the nation.
  - Providing access to confidential aggregate CDC data through the Research Data Center.
- Support data collection methodology research and dissemination to meet increasing data requests 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.

**SURVEILLANCE, EPIDEMIOLOGY, INFORMATICS, AND LABORATORY SCIENCE BUDGET REQUEST**

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Budget Authority	\$111.661	\$108.043	\$0.000	-\$108.043
PHS Evaluation Transfer	\$109.086	\$109.086	\$217.541	+\$108.455
ACA/PPHF	\$47.000	\$45.000	\$65.000	+\$20.000
<b>Total</b>	<b>\$267.747</b>	<b>\$262.129</b>	<b>\$282.541</b>	<b>+\$20.412</b>

Program Overview: CDC's public health scientific support services provide a crosscutting, scientific perspective to public health sciences across the agency, including surveillance, epidemiology, informatics, and laboratory science. CDC works to advance the science and practice of surveillance by managing various surveillance systems with cross-CDC utility, such as the Behavioral Risk Factor Surveillance System (BRFSS) and the National Notifiable Diseases Surveillance System (NNDSS). CDC supports information management projects across the agency through a shared informatics support model and ensures that CDC programs and state and local health departments prepare for and use electronic data in accordance with the Health Information Technology for Economic and Clinical Health (HITECH) Act-related Meaningful Use objectives. CDC provides expertise in scientific publication and systematic reviews and puts epidemiology to work with products and services such as the *Morbidity and Mortality Weekly Report (MMWR)*, the Guide to Community Preventive Services, and Epi Info™. CDC's laboratory science, policy, and practice program provides leadership, advocacy, and training services to strengthen the quality of laboratory science at CDC, in the United States, and globally by providing guidelines and recommendations for public health laboratories.

Budget Proposal: CDC's FY 2013 request of \$282,541,000 for surveillance, epidemiology, informatics, and laboratory science, including \$65,000,000 from the Affordable Care Act Prevention and Public Health Fund, is an overall increase of \$20,412,000 above the FY 2012 level. Of the \$20,412,000 increase, \$20,000,000 will support state public health laboratories' adoption of proven, high-efficiency operating models to achieve cost efficiencies and improved quality of testing.

In addition, the budget maintains CDC's capacity to support the ongoing quality, timeliness, and accessibility of public health data for decision making; development of methods to improve quality and access to information from EHRs, such as communicable disease reports; collection and analysis of behavioral risk factor data to address health conditions; publication and dissemination of scientific products used for public health intervention, including the *Morbidity and Mortality Weekly Report*, Guide to Community Preventive Services, and Vital Signs; capacity to conduct research through the Public Health Library Information Center; and provision of new laboratory diagnostics, training of laboratory staff, and assurance of laboratory practice quality standards and guidelines.

***Behavioral Risk Factor Surveillance System***

Program Overview: CDC funds state health departments through cooperative agreements to administer the BRFSS. The BRFSS is the largest ongoing telephone survey system in the world and is the only nationwide health system that collects state-specific information on health status, health behaviors, preventive health practices, and access to health care. The structure of the BRFSS: 1) ensures standardized administration of core and optional survey questions across all 55 participating states and territories, 2) reserves space within the core component for questions on emerging issues that can be added to the survey rapidly, within an ongoing data collection cycle, and 3) provides states the flexibility to add questions. States may choose to administer optional BRFSS modules, which either expand on topics addressed in the core component or collect information on additional health topics. State-added questions target specific state needs and are not part of the official BRFSS questionnaire or dataset. BRFSS datasets are made available to the public within four months after annual data collection ends.

Recent accomplishments:

- Improved population coverage of the BRFSS by achieving at least 10 percent of completed interviews in all states from adults in a household with only a cell phone. Nationally, about 28 percent of adults live in a cell phone-only household.
- Completed over 35,000 interviews from December 2010 to November 2011 for the Gulf States Population Survey (GSPS). The GSPS is the first BRFSS-like stand-alone survey of its kind and might serve as a model for future BRFSS stand-alone surveys.

In FY 2013, CDC will:

- Fund grantees to increase the proportion of completed cell phone interviews relative to the proportion of completed landline telephone interviews to 20 percent (per-interview costs for cell-phone interviews are two to three times more expensive than landline interviews). This will address possible reductions in the representativeness of the BRFSS, specifically in the 18 to 44 year old population, caused by increases in the proportion of U.S. households that contain only cell phones.
- Develop estimates for all counties in the United States for 11 health indicators, including obesity, diabetes, smoking, and access to care, that state and local health departments can use to address health disparities within the state and target resources more efficiently.
- Complete data collection and initial analysis of data from the GSPS, a special BRFSS-like survey that collects data in Gulf Coast counties affected by the Deepwater Horizon oil spill. GSPS data collection will yield a dataset—amenable to analysis by CDC, the Substance Abuse and Mental Health Services Administration, and participating states—to determine mental and behavioral health status and assess the need for health services in the populations across the affected areas.
- Provide technical assistance to states in survey operations to ensure standardized, high-quality data.

***Behavioral Risk Factor Surveillance System (BRFSS) Grant Table<sup>1</sup>***

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget
Number of Awards	57	57	57
Average Award	\$0.222	\$0.222	\$0.222
Range of Awards	\$0.043–\$0.390	\$0.043–\$0.415	\$0.043–\$.415
Number of New Awards	2	0	0
Number of Continuing Awards	55	57	57

<sup>1</sup>BRFSS is funded through both budget authority and PPHF dollars.

***National Notifiable Diseases Surveillance System***

Program Overview: The NNDSS is a cornerstone of the nation's ability to identify, monitor, and investigate diseases and conditions. At the federal level, NNDSS focuses on monitoring infectious disease morbidity for state and territorial reportable diseases designated as nationally notifiable. Data provided to NNDSS comes from health care providers and laboratories that are legally mandated to report conditions of public health importance to state and local health departments. These nationally notifiable diseases are specified by state and territorial disease reporting laws and regulations. States voluntarily report data through NNDSS, the only national source for these data. The NNDSS provides the standards for data collection, transmission, and management, which are updated periodically in accordance with developments in public health surveillance and health information technology.

NNDSS provides funding to states, territories, and local health departments using the Epidemiology and Laboratory Capacity (ELC) Cooperative Agreement. The National Electronic Disease Surveillance System (NEDSS) serves as the transmission component of the NNDSS and is supported by funding for staff and technology in state, territorial, and local health departments. The NEDSS Base System (NBS), a software program developed by CDC, supports state surveillance systems in standardized reporting. The NNDSS program will continue to support states in the implementation of electronic laboratory reporting (ELR) in order to meet objectives in Meaningful Use.

Recent accomplishments:

- Provided funding to 56 (in FY 2011) and 63 (FY 2012) states/territories/local health departments to support electronic disease surveillance for personnel and technology.
- Aggregated data from 50 states each week and shared these data with CDC programs and the general public via the *MMWR*.
- Implemented, with states, national immediate case notification guidelines to enhance reporting to CDC. These guidelines enhance CDC's ability to collect data, rapidly address health problems, and support International Health Regulations.
- Provided training and technical assistance to 12 states to receive electronic laboratory reports consistent with Meaningful Use.

In FY 2013, CDC will:

- Improve quality of and access to data on nationally notifiable diseases. CDC will use new data warehousing structures, simplify methods to access data, and expand the availability of essential disease-specific data elements (beyond core data elements routinely part of all case reports).
- Expand the adoption of ELR in each state as part of notifiable disease surveillance in order to increase the capacity of eligible health care providers to meet Meaningful Use of Electronic Health Record (EHR) standards.
- Develop and adopt standards to exchange, aggregate, analyze, and disseminate data on nationally notifiable diseases by collaborating with CDC Programs, the Council on State and Territorial Epidemiologists (CSTE), and state and territorial health departments.

### ***Epidemiology***

Program Overview: CDC contributes to health through prevention by providing scientific expertise for the Guide to Community Preventive Services (Community Guide) and technical assistance to decision makers and public health practitioners who want help in selecting and implementing recommendations; disseminating timely, useful health information through the *MMWR*; and developing innovative methods to collect, analyze, and communicate public health surveillance information.

Recent accomplishments:

- Reached all state and local health departments and over 95 percent of local boards of health with evidence-based recommendations from the Community Guide.
- Developed and distributed weekly Public Health Library and Information Center (PHLIC) Science Clips, providing applied research and prevention science to over 5,400 state and local subscribers, including some who would not have access to emerging science due to local budget cuts, and responded to over 750,000 internal requests for library print and electronic resources in support of CDC research.

- Provided timely information and recommendations for solving public health problems to over 130,000 subscribers through electronic and print communications published in the *MMWR*. Through the *MMWR*, CDC promoted good public health practices among health care professionals and supported their career development by offering free *MMWR* Continuing Education (CE) credits for reading the weekly articles and Recommendations and Reports.
- CDC Vital Signs reached over one million people with a monthly *MMWR* Early Release, Fact Sheet, and Communications package describing new analyses of the latest available data to provide a call-to-action on 12 topics of great public health importance, including prescription narcotic overdose, health care-acquired infections, asthma, and food safety.
- Supported scientists in the United States and abroad with Epi Info™, software tools that help epidemiologists collect and manage data when investigating and controlling disease outbreaks and adverse health conditions.

In FY 2013, CDC will:

- Continue to build the scientific evidence base for Community Guide recommendations by conducting and updating reviews to address significant public health problems.
- Expand support of state and local public health decision making through the PHLIC by increasing the number of subscribers to Science Clips and using innovative strategies to link Science Clips to other critical sources of public health data, such as CDC Vital Signs.
- Reach more readers with critical information about disease prevention and control in the *MMWR* by partnering with constituents in state and local health departments, colleagues overseas, clinical medicine counterparts, and colleagues across CDC including the Center for Global Health (CGH) and the Office for State, Tribal, Local, and Territorial Support (OSTLTS).

### ***Informatics***

Program Overview: CDC's informatics program uses information science and technology to improve the effectiveness and efficiency of programs to prevent disease, disability, and death. This includes the use of information technology (IT) as an integral element of CDC surveillance systems. CDC develops policies and standards for information exchange between health care providers, public health agencies, and emergency response officials. The program supports information management projects for at least 30 programs across all CDC centers, institutes, and offices through a shared informatics support model that translates public health needs into information processes that are cost effective, strategic, and congruent with the larger health IT world. The program operates critical messaging, directory, storage, emergency countermeasure inventory management, and routing systems used across the nation's public health system. CDC also works with health care organizations around EHR systems to provide prevention-oriented decision support for clinical providers. In addition, the program advances the knowledge of public health informatics and provides information on best practices to the local, state, federal, and global public health workforce.

Recent accomplishments:

- Created a cooperative agreement to bring 500 hospital labs into ELR with their respective public health agencies, and helped the nation's health departments upgrade to a new HITECH ELR standard.

- Increased the number of state and city health departments testing HITECH Act Meaningful Use-compliant electronic lab reports, immunization reports, or surveillance reports from zero to over 38 in nine months. CDC rapidly stood-up implementation guides, mapping tables, message translation and validation tools, training, and technical assistance to help public health departments keep up with fast-paced changes related to HITECH's Meaningful Use Incentive Program.
- Established an EHR-alerting pilot project in collaboration with Chicago public and private partners to provide public health alerts and reminders to clinicians during patient care.
- Implemented the new Applied Public Health Informatics Laboratory and Research Cloud, which enables CDC scientists across 22 programs to build, evaluate, and train on new public health tools and technologies. This improved selection and use of technology, at significant cost-savings, speed, and convenience, when compared to prior methods.
- Disseminated millions of public health tools through the CDC Wide-ranging Online Data for Epidemiologic Research (WONDER) website. Over 700,000 users visited the WONDER website in FY 2011 and WONDER provided over two million customized statistics tables, charts, and maps for health departments, health planners, academics, and the general public worldwide. In FY 2011, WONDER added nine new and three updated data sets, including mortality, sexually transmitted disease, infant mortality, cancer incidence, tuberculosis, vaccination-adverse events, and influenza/pneumonia mortality. Data.gov released 11 additional "tool" descriptions regarding CDC WONDER, and the WONDER Application Programming Interface makes its content available to private application developers. CDC WONDER serviced over 29 million web requests in FY 2011, greatly reducing work for data users and CDC (the data provider) alike.

In FY 2013, CDC will:

- Use health information technology and exchange (as enhanced by the HITECH Act) to improve health and disease surveillance, immunization rates, and the delivery of preventive services. Emphasis will be on improving local and state capacity to receive and manage information from EHRs for both Stage 1 and Stage 2 of Meaningful Use, particularly implementing new secure message transport protocols, electronic lab reporting, and surveillance of biothreats, health care-acquired infections, heart health, and cancer.
- Enhance public health efficiency and effectiveness through better information management, reduce costs, and enhance interoperability using shared practices and services across multiple health information systems.
- Advance and share knowledge about how information technology can improve health outcomes through research, development, and electronic communication with health care providers and the public.

### ***Laboratory Science, Policy, and Practice***

Program Overview: CDC's laboratory science, policy, and practice program works to strengthen the capacity of public health laboratories in every state to perform their critical role in protecting the public's health. The program helps public health laboratory leaders and professionals by developing and providing science-based recommendations for best practices; providing technical assistance on rapidly evolving testing protocols, technologies, and informatics applications; delivering training in cutting-edge testing methods both in laboratories and through using distance-based methods; and supporting commercialization of CDC inventions to ensure their wide availability.

CDC serves the nation's more than 230,000 clinical laboratories by working with the Centers for Medicare and Medicaid Services (CMS) to develop regulatory standards to assure the accuracy and

reliability of clinical laboratory testing. CDC also contributes to the development of voluntary practice standards and guidelines used domestically and globally to improve laboratory testing in support of quality health care. In addition, CDC develops and disseminates companion educational products to improve practitioners' understanding and use of standards and guidelines. Through its quality improvement research program, CDC conducts studies to establish a scientific basis for policy decisions, evaluate quality gaps, and develop tools and interventions to help address the need for safe, timely, effective, efficient, equitable, and patient-centered health care.

Recent accomplishments:

- Trained over 6,300 laboratory professionals in biosecurity and biosafety best practices and in testing for influenza, tuberculosis, vaccine-preventable diseases, newborn screening, parasitology, and other key subjects in FY 2010.
- Developed CDC's first agency-wide Select Agents and Toxins Compliance Policy to assist CDC laboratories that work with select agents and toxins in complying with the federal regulation in order to guard against malicious and unintentional use of dangerous pathogens.
- Provided 830,156 specimens in FY 2011 from CDC's repository of extensive and unique biological collections to researchers in the private sector, academic institutions, and CDC programs for research that supports development of new vaccines, diagnostic tests, and health interventions on diseases and conditions such as human immunodeficiency virus (HIV), severe acute respiratory syndrome (SARS), Hantavirus, Legionnaire's disease, and lead poisoning.
- Expanded the availability of CDC-invented technologies and tools to public health and clinical care providers issuing 17 technology licenses and providing unique materials for research purposes to private firms through 20 patent-based material transfer agreements in FY 2011.

In FY 2013, CDC will:

- Develop and deliver 60 training courses in advanced public health laboratory practice to state and local public health professionals.
- Provide laboratory practice quality standards, guidelines, and educational products that serve and support clinical and public health laboratories and, as technology evolves, evaluate and address gaps in quality practices.
- Manage collections of biological specimens (totaling 5,016,840 as of December 2011) that CDC and other scientists use to identify new threats, develop vaccines, and address conditions such as lead poisoning and nutritional deficiencies.
- Promote and accelerate transfer of 30 CDC-developed diagnostic devices and other inventions. For example, provide new diagnostic tools for use by state health labs and other public health practitioners, including tests for influenza, West Nile virus, HIV, and dengue fever.
- Coordinate with public health laboratories to adopt proven, high-efficiency operating models—such as multi-state regionalization of testing and standardized test technologies—to achieve both cost efficiencies and improved quality, enabling them to reestablish and sustain essential testing capacity.

**PUBLIC HEALTH WORKFORCE AND CAREER DEVELOPMENT BUDGET REQUEST**

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Budget Authority	\$36.134	\$35.929	\$35.695	-\$0.234
ACA/PPHF	\$25.000	\$25.000	\$25.000	\$0.000
<b>Total</b>	<b>\$61.134</b>	<b>\$60.929</b>	<b>\$60.695</b>	<b>-\$0.234</b>

Program Overview: 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. CDC’s fellowship programs provide opportunities to develop public health skills while providing service to state and local health departments. These programs also fill critical gaps in key areas such as epidemiology, informatics, prevention effectiveness (health economics and decision sciences), preventive medicine, program management, and policy analysis. Routine placement of fellows in the field also strengthens the ability of state and local health departments to respond to public health problems and emergencies. The fellowships include the Emerging Leaders Program, Epidemic Intelligence Service (EIS), Presidential Management Fellows Program, Prevention Effectiveness Fellowship Program, Preventive Medicine Residency and Fellowship, Public Health Associate Program (PHAP), Public Health Informatics Fellowship Program (PHIFP), and Public Health Prevention Service (PHPS). As physicians take care of the health of patients during their on-the-job learning during a medical residency, public health professionals take care of the health of a population during their on-the-job training as public health fellows.

Recent accomplishments:

- Local, state, and international health agencies also request public health informatics assistance (i.e., InfoAids) from CDC. In FY 2011, CDC responded to eight InfoAids requests. Of the eight InfoAids, two of these were joint InfoAids/Epi-Aids, which provided assistance to Guam (assessed the capacity of Guam’s communicable disease surveillance system to monitor mobile populations) and Ohio (examined influenza-like illness mortality in a residential facility for children and young adults with developmental disabilities).
- Forty-six PHPS fellows were assigned to state and local public health organizations in FY 2011 for two-year field assignments to address critical public health needs. The work of these fellows included coordinating a response to the incidence of *Clostridium difficile* in hospitals that resulted in a significant reduction in the level of infection among staff and patients.
- One hundred twenty-four PHAP associates were assigned to state, tribal, local, and territorial health agencies in FY 2011 as part of their two-year assignments aimed at launching them into public health-related careers. The associates serve on the frontlines of public health, providing screening services, individual and community outreach and education, infectious disease investigation services such as partner notification, and support for emergency responses to outbreaks such as foodborne diseases, seasonal diseases like influenza, or natural disasters that put communities at high risk for diseases.
- Added a new learning management system, CDC TRAIN, to the CDC Learning Connection, that provides advanced search capabilities for a catalog of over 5,000 courses. Since the launch of CDC TRAIN in August 2011, over 16,000 learners have registered.
- In FY 2011, CDC’s CE Program accredited 168 new educational activities and had over 80,000 course registrations. CDC is the only HHS agency accredited to award six types of CE credits for health professionals and others.

**Budget Proposal:** CDC’s FY 2013 request of \$60,695,000 for public health workforce and career development, including \$25,000,000 from the Affordable Care Act Prevention and Public Health Fund, is \$234,000 below the FY 2012 level. Funds will maintain CDC's capacity to support fellowship programs that fill critical gaps in the public health workforce, provide on-the-job training, and provide continuing education and training for the health professional workforce.

In FY 2013, CDC will:

- Train the next generation of public health leaders through fellowship programs that develop public health skills through service and experiential on-the-job learning.
- Expand access to high-quality public health e-learning products and training for the health professional workforce.
- Provide instructional design services for innovative e-learning products and accredit educational activities for CE credit for a range of health professions.
- Build linkages between public health and medical care through a one-year practicum for graduates of the EIS fellowship program that will focus on patient safety and quality improvement challenges.
- Enhance support to state and local public health agencies by extending PHPS fellows’ two-year field assignments through a one-year, competency-based residency. This residency will allow for the fellow to focus more exclusively on an issue or program area that the state or local area identifies as a significant challenge to the health or condition of its population.
- Strengthen public health informatics assistance to state and local public health agencies through additional field placements of PHIFP fellows and graduates.

**AFFORDABLE CARE ACT PREVENTION AND PUBLIC HEALTH FUND**

(dollars in millions)	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President’s Budget	FY 2013 +/- FY 2012
<b>ACA/PPHF</b>	<b>\$72.000</b>	<b>\$70.000</b>	<b>\$90.000</b>	<b>+\$20.000</b>

The following activities are included:

- Health Care Surveillance/Health Statistics – \$35,000,000
- Public Health Workforce Capacity – \$25,000,000 (included in the Public Health Workforce narrative)
- Community Guide – \$10,000,000
- Laboratory Efficiencies Initiative (LEI) – \$20,000,000

***Health Care Surveillance/Health Statistics***

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 ACA. The NHIS will track the ACA impact on care access and utilization. The increase in the NHIS sample will provide stable estimates for targeted populations. The NAMCS sample of physicians will expand to permit greater precision for estimates related to care that different population groups and groups with different conditions receive. 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 NAMCS and to hospital outpatient departments through NHAMCS will expand the data collected on clinical management and on patient's risk factors for those with heart disease and stroke during the 12 months before the sampled visit. These data and resulting analysis will permit monitoring and evaluating goals to increase prevention through health care programs and expanded insurance coverage.

CDC will provide funding to the four states and territories that have not implemented the re-engineered, web-based electronic birth record systems and 2003 U.S. Standard Birth Certificate. This will build on \$2,500,000 provided in FY 2012 to implement electronic birth record systems in four states.

CDC will utilize the BRFSS to collect more detailed state-specific data for state- and sub-state adult populations on health insurance coverage, access to health care, and use of clinical preventive services than is currently available in the BRFSS. State and local health departments can use this data to: 1) establish a timely baseline for monitoring the impacts of the ACA on state health care access and utilization and 2) evaluate the impacts of the ACA on state prevalence estimates for diseases, health conditions, and risk behaviors for the leading causes of death and disability.

### ***Community Guide***

The Community Preventive Services Task Force's role is to develop additional topic areas for new recommendations and related interventions; update all existing reviews every five years; improve integration with federal government health objectives and related target setting; enhance dissemination of recommendations; provide technical assistance to health care professionals, agencies, and organizations requesting help in implementing Community Guide recommendations; and provide annual reports to Congress and related agencies in identifying gaps in research and recommending priority areas that deserve further examination.

CDC will provide ongoing administrative, research, and technical support for the operations of the Task Force. CDC will: 1) increase production of Community Guide reviews and related Task Force recommendations that address high-priority public health needs; and 2) enhance dissemination and implementation support to assist policymakers, practitioners, and other decision makers in accessing and using Task Force recommendations. These recommendations identify programs, services, and policies proven effective in a variety of real-world settings, such as communities, worksites, schools, and health plans. Task Force recommendations empower community, local, state, federal, tribal, territorial, corporate, public health, and health care decision makers to optimize resources to 1) protect and improve health, 2) reduce demand for future health care spending that is driven by preventable disease and disability, and 3) increase productivity and economic competitiveness of the U.S. workforce.

### ***Laboratory Efficiencies Initiative (LEI)***

A new effort for FY 2013 will be the Laboratory Efficiencies Initiative (LEI). The nation's public health laboratories perform critically needed services to protect the public's health and support patient treatment. But many laboratories have had to reduce or eliminate critical services because of deep budget cuts and other serious challenges. The LEI will make competitive grants to: 1) consortia of state public health laboratories to support implementation of shared testing services in regions and 2) state public health laboratories to implement high-efficiency management practices that have been proven effective in the field. Laboratories will also pilot-test additional, novel management practices for national dissemination and appropriate adoption. The LEI's strategic goal is to help assure that public laboratories in all U.S. communities have the capacity to address infectious disease outbreaks, mitigate environmental and hazardous health threats, and communicate high-quality test results rapidly to public health and clinical care decision makers. To achieve critically important, long-term sustainability, public health laboratories will use LEI financial and technical assistance to adopt such high-efficiency management practices as:

- Regionalization of testing across states and consolidation of testing services within states;

- Contracted testing services;
- Generation of new revenue streams for states;
- Procurement savings through joint purchasing and other mechanisms; and
- Adoption of cost-saving technologies and standard testing platforms.

**PERFORMANCE**

***Program: Health Statistics***

**Performance Measures for Long Term Objective: Monitor trends in the nation’s health through high-quality data systems and deliver timely data to the nation’s health decision-makers**

Measure	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
<u>8.A.E.1</u> : The number of months for release of data as measured by the time from end of data collection to data release on internet (Outcome and Efficiency)	FY 2009: 7.5 (Target Exceeded)	9.4	9.3	-0.1
<u>8.A.1.1a</u> : Percentage of key data users and policy makers, including reimbursable collaborators that are satisfied with data quality and relevance: web survey (Outcome)	FY 2011: 77.9% (Target Exceeded)	75.2%	75.2%	Maintain
<u>8.A.1.1b</u> : Percentage of key data users and policy makers, including reimbursable collaborators that are satisfied with data quality and relevance: federal power users (Outcome)	FY 2011: 100% Good or Excellent (Target Met)	100% Good or Excellent	100% Good or Excellent	Maintain
<u>8.A.1.3</u> : Number of web visits as a proxy for the use of NCHS data <sup>2</sup> (Output)	FY 2010: 8.7 Million (Target Exceeded)	8.5 Million	10.5 Million	+2
<u>8.E</u> : Number of key elements of the health care system for which data are collected (Output)	FY 2011: 3 (Target Met)	3	3	Maintain
<u>8.F</u> : Number of communities visited by mobile examination centers from the National Health and Nutrition Examination Survey (Output)	FY 2011: 15 (Target Met)	15	15	Maintain
<u>8.G</u> : Number of households interviewed in the National Health Interview Survey <sup>1,3</sup> (Output)	FY 2011: 39,926 <sup>4</sup> (Target Not Met but Improved)	46,500	55,000	+8,500
<u>8.H.1</u> : Number of physicians surveyed in the National Ambulatory Medical Care Survey <sup>1,3</sup> (Output)	FY 2011: 4,012 (Target Exceeded)	10,200	12,000	+1,800

Measure	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
<u>8.H.2</u> : Number of patient visit records surveyed in the National Ambulatory Medical Care Survey <sup>1,3</sup> (Output)	FY 2011: 40,000 (Target Exceeded)	90,000	100,200	+10,200
<u>8.I</u> : Number of states funded to provide electronic birth records (either completely or in part) <sup>1,3</sup> (Output)	FY 2011: 0 (Historical Actual)	4	4	Maintain

<sup>1</sup>Some targets reflect ACA/PPHF funding.

<sup>2</sup> Results for FY 2011 are not reported due to Omniture technical issues which prevented collection of site visits due to RSS traffic. Results will be available for FY 2012.

<sup>3</sup>The increase in NHIS, NAMCS and electronic birth records will vary depending on when funds are received.

<sup>4</sup>The target improved but was not met by 74 households (out of a 1,000 household increase).

**Performance Trends:** CDC collaborated with the National Association for Public Health Statistics and Information to improve the timeliness and quality of information derived from vital records and vital registration systems operated by cities, states, and territories. Thirty-eight states, the District of Columbia, and New York City re-engineered birth registration systems, corresponding to 87 percent of all births in the United States, by the end of FY 2011. By January 2014 CDC expects that all jurisdictions will submit birth records electronically (8.I). In addition, 38 states re-engineered death registration systems, but a substantial number of these systems were not fully implemented at the state and local level and among the key data providers, such as physicians.

Over the last few years, CDC increased the number of interviews for two surveys—National Health Interview Survey and National Ambulatory Medical Care Survey. In addition, in order to monitor and inform current national health reform efforts, CDC will increase the sample size of these two surveys in FY 2013 to demonstrate the impact of improved access to care on prevention of illness, management of chronic conditions, and ultimately, health outcomes (8.G, 8.H). The following indicators help the program measure its ability to provide useful, timely, and high-quality data:

- Assess the number of months for release of data. CDC exceeded the target of 9.7 months and released FY 2009 data within 7.5 months (8.A.E.1).
- Assessing user satisfaction drives program improvements. In 2011, CDC interviewed Federal Power Users (users in HHS sister agencies) to assess their satisfaction with CDC products and services including data quality, ease of data accessibility and use, professionalism of staff, relevance of data to major health issues, and relevance of data to user needs. CDC met the target of 100 percent Good or Excellent (Measure 8.A.1.1b).

***Program: Surveillance, Epidemiology, and Laboratory Services***

**Performance Measures for Long Term Objective: Lower barriers to data exchange across jurisdictions for public health surveillance and response**

Measure	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
<u>8.B.1.2</u> : Increase the number of jurisdictions that can send at least one type of electronic message to CDC in compliance with published standards (Output)	FY 2011: 30 (Target Met)	42	43	+1

NARRATIVE BY ACTIVITY  
PUBLIC HEALTH SCIENTIFIC SERVICES  
BUDGET REQUEST

Measure	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
<u>8.B.1.2</u> : Increase the number of jurisdictions that can send at least one type of electronic message to CDC in compliance with published standards (Output)	FY 2011: 30 (Target Met)	42	43	+1
<u>8.A</u> : Increase the number of metropolitan/ micropolitan statistical areas (i.e. local) for which BRFSS <sup>1</sup> data is available <sup>2</sup> (Output)	FY 2010: 194 (Historical Actual)	150	150	Maintain
<u>8.K</u> : Sustain the number of states developing NEDSS-compatible systems, in deployment, or lie with the NEDSS <sup>3</sup> Base System (Output)	FY 2011: 50 (Target Met)	50	50	Maintain

<sup>1</sup>Behavioral Risk Factor Surveillance System

<sup>2</sup>Targets reflect ACA/PPHF funding

<sup>3</sup>National Electronic Disease Surveillance System

**Performance Measures for Long Term Objective: Improve access to and reach CDC's scientific health information among key audiences to maximize health impact**

Measure	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
<u>8.B.2.1</u> : 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. Increase the number of subscribers to the Morbidity and Mortality Weekly Report (MMWR) (Outcome)	FY 2011: 139,210 (Target Exceeded)	145,648	152,085	+6,437
<u>8.B.2.2</u> : Increase the electronic media reach of CDC Vital Signs through the use of mechanisms such as CDC.gov and social media outlets (Output)	FY 2011: 1,113,531 (Target Exceeded)	1,169,208	1,215,976	+46,768
<u>8.B.2.5</u> : Increase awareness and use of the Guide to Community Preventive Services, and Task Force findings and recommendations, using page views as proxy <sup>4</sup> (Outcome)	FY 2011: 927,357 (Baseline)	973,724	1,032,147	+58,423

<sup>4</sup>Targets reflect ACA/PPHF funding

**Performance Measures for Long Term Objective: 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	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
8.B.3.1: Evaluate the impact of National Laboratory Training Network training programs on laboratory practices (Outcome)	FY 2011: 66.2% (Target Met)	More than 50% of public health and clinical laboratorians attending NLTN public health laboratory workshops either updated or improved laboratory policies or practices as a result of the training.	More than 50% of public health and clinical laboratorians attending NLTN public health laboratory workshops either updated or improved laboratory policies or practices as a result of the training.	No Change

Behavioral Risk Factor Surveillance System (BRFSS) Performance Trends: In FY 2011 CDC completed over 400,000 BRFSS interviews. As a result of BRFSS’s uniquely large sample size, CDC began meeting the growing demand for localized information by increasingly providing sub-state level BRFSS data. The number of metropolitan and micropolitan statistical areas (MMSA) with available BRFSS data increased from 177 in 2008 to 194 in 2010, although the 2010 figure reflects a special, triennial survey conducted by Florida sampling every county in the state. CDC expects the number of MMSAs to decline to 150 in FY 2012 and FY 2013 (Measure 8.A). This decline reflects the anticipated reduction in the BRFSS total sample size as states decrease the landline sample in order to increase the cell-phone sample. Cell phone interviews are relatively more costly, but are necessary to capture health behaviors within the 18-44 year old age group, which constitutes nearly half of the U.S. adult population and more frequently relies on cellular telephones than landline telephones. Additionally, CDC will change the surveillance analysis methodology for MMSAs in FY 2012, requiring the completion of a greater number of county-level surveys (from 250 to 500 starting in FY 2012).

National Notifiable Disease Surveillance System (NNDSS) Performance Trends: CDC uses data from NNDSS to identify opportunities for immediate disease control and prevention, monitor trends and the effectiveness of prevention and control activities, conduct program planning and evaluation, develop public health policy, and conduct research. NNDSS provides funds from the ELC cooperative agreement to state, territory, and local health departments to build and maintain epidemiologic and surveillance capacity to support electronic disease reporting and information exchange using a compatible National Electronic Disease Surveillance System (NEDSS). Currently, 18 states and Washington, D.C. use the CDC-developed NEDSS-Base System, 28 states use a state- or vendor-developed NEDSS-compatible system, and the remaining four states are either in the process of adopting or changing their NEDSS-compatible system. As a result, jurisdictions are able to implement integrated surveillance systems to improve their ability to identify cases of illness, manage investigation and response activities, and allow data analyses for public health action. Further, jurisdictions improved their ability to exchange data electronically with partners for surveillance purposes (Measure 8.K).

Epidemiology Performance Trends: CDC disseminated recommendations for solving public health problems to over 130,000 clinicians, epidemiologists, laboratorians, and other public health professionals

through electronic and print communications published in the *MMWR*. The number of *MMWR* subscribers increased by approximately 30,000 since 2008. Electronic subscribers increased by over 10 percent in FY 2011 (Measure 8.B.2.1). Similarly, electronic media reach of CDC Vital Signs—a monthly *MMWR* feature that targets public, health care professionals, and policymakers—increased to over one million in the program's first year, exceeding the target (Measure 8.B.2.2). CDC measures Vital Signs media reach by page views ([www.cdc.gov/vitalsigns](http://www.cdc.gov/vitalsigns)) and followers on social media groups. The audience exposed to Vital Signs in all forms, which far exceeded expectations, expanded due to growing print, broadcast, and cable media interest. Due to media saturation, CDC does not expect continued growth in this manner, making this a unique occurrence. Therefore, CDC expects slower, sustainable growth in 2012 and beyond.

CDC established a performance measure to track awareness and use of Community Guide findings and recommendations (8.B.2.5). In the short term a proxy measure—page views of the Community Guide website ([www.thecommunityguide.org](http://www.thecommunityguide.org))—will monitor awareness. In 2011 CDC experienced 927,357 page views on the Community Guide website. CDC is currently developing a baseline of state and local awareness and use to measure how decision makers use the Community Guide's evidence-based recommendations and findings. Additionally, CDC tracks the number of reviews completed by the Community Guide; the Community Guide completed nine reviews in FY 2011, including updates of earlier reviews.

Informatics Performance Trends: In FY 2011 Public Health Information Network (PHIN) standards enabled 21 states to demonstrate their capability to exchange public health alerts across state lines within one hour. In FY 2011 CDC met its target of 30 unique jurisdictions capable of electronically exchanging public health data for infectious disease cases with CDC using Public Health Information Network standards (Measure 8.B.1.2). By December 2011 CDC certified 30 jurisdictions for electronic tuberculosis (TB) notifications, 22 jurisdictions for *Varicella* notifications, and six jurisdictions for a generic notification for multiple diseases.

Laboratory Science Performance Trends: In FY 2011, 66.2 percent of the public health and clinical laboratorians who completed the CDC and National Laboratory Training Network (NLTN) training on biosecurity and biosafety reported the ability to upgrade key practices (Measure 8.B.3.1). CDC collected performance data through course reaction evaluations, pre- and post-tests, and impact surveys six months after the training. CDC then analyzed data to determine trainees' improvement in knowledge and practice and improve the training curriculum. For state public health laboratory trainers who complete a prerequisite train-the-trainers course, CDC annually updates and disseminates the biosafety and biosecurity course so they can deliver training to professionals in sentinel clinical laboratories throughout the country.

***Program: Public Health Workforce and Career Development<sup>5</sup>***

**Performance Measures for Long Term Objective: CDC will develop and implement training to provide for an effective, prepared, and sustainable health workforce able to meet emerging health challenges.**

Measure	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
8.B.4.1: Maintain the number of all CDC trainees who join public health fellowship programs in local, state, and federal health departments to participate in training in epidemiology, preventive medicine, or public health leadership and management <sup>6</sup> (Output)	FY 2011: 218 (Target Exceeded)	200	200	Maintain

Measure	Most Recent Result	FY 2012 Enacted Target	FY 2013 Target	FY 2013 +/- FY 2012
8.B.4.1: Maintain the number of all CDC trainees who join public health fellowship programs in local, state, and federal health departments to participate in training in epidemiology, preventive medicine, or public health leadership and management <sup>6</sup> (Output)	FY 2011: 218 (Target Exceeded)	200	200	Maintain
8.B.4.2: Increase the number of CDC trainees in state, tribal, local, and territorial public health agencies <sup>7</sup> (Output)	FY 2011: 309 (Target Exceeded)	237	248	+11
8.B.4.3: Maintain the number of new CDC trainees who join public health fellowship programs in epidemiology, preventive medicine, public health leadership and management, informatics, or prevention effectiveness, and participate in training at federal, state, tribal, local, and territorial public health agencies <sup>8</sup> (Output)	FY 2011: 197 (Target Exceeded)	176	176	Maintain

<sup>5</sup>Targets reflect ACA/PPHF funding.

<sup>6</sup>8.B.4.1 includes all (new and continuing) CDC-funded trainees in the Epidemic Intelligence Service (EIS), Public Health Prevention Service (PHPS), and Preventive Medicine Residency/Fellowship (PMR/F).

<sup>7</sup>8.B.4.2 includes all (new and continuing) CDC-funded trainees in EIS, PHPS, PMR/F, Public Health Informatics Fellowship Program (PHIFP), Public Health Associate Program (PHAP), Emergency Infectious Diseases (EID) Laboratory Fellowship, CDC/CSTE Applied Epidemiology Fellowship, Post-EIS Practicum (PEP), PHPS Residency, and Applied Public Health Informatics Fellowship (APHIF) assigned to state, tribal, local, and territorial public health agencies.

<sup>8</sup>8.B.4.3 includes new CDC-funded trainees in EIS, PHPS, PMR/F, PHIFP, Prevention Effectiveness Fellowship (PEF), Presidential Management Fellows (PMF) program, and PHAP.

**Performance Trends:** In 2011, 78 percent of CDC’s unique fellowship programs’ graduates pursued careers in public health, which contrasts with the less than 25 percent of graduates of schools of public health who pursue careers in public health practice. Measures 8.B.4.1 and 8.B.4.3 assess continued contributions to the public health workforce pipeline through CDC’s experiential fellowship programs. Measure 8.B.4.1 assesses the number of new and continuing trainees in three long-standing CDC fellowship programs. Measure 8.B.4.3 assesses the annual change in the number of new trainees in a larger set of CDC’s fellowship programs. In FY 2011, CDC exceeded its targets for these two measures. CDC sets the targets based on the typical, annual class size for each of the fellowship programs included in this measure.

CDC helps bolster the public health workforce capacity for state and local partners through several key initiatives and efforts. Measure 8.B.4.2 assesses CDC’s increased support to state, tribal, local, and territorial (STLT) public health agencies through the placement of field trainees. By FY 2011 CDC increased the number of fellows in STLT public health agencies from 119 trainees in 2009 to 309, exceeding the FY 2011 target. CDC also created the Post-Epidemic Intelligence Service Practicum, Public Health Prevention Service Residency, and Applied Public Health Informatics Fellowship in FY 2011 using Prevention and Public Health (PPHF) support. These programs will retain 22 fellowship graduates—for a one-year practicum at the state and local level. This will strengthen workforce capacity in several critical disciplines, such as applied epidemiology, public health management, and informatics. At the end of FY 2011, 309 field trainees (210 supported by PPHF) were on assignment in 43 states, Washington, D.C., Puerto Rico, and three tribal locations. This measure supports HHS Strategic Plan Goal Five, Objective C.

**IT INVESTMENTS**

Because of investments in 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 IT support multiple programs within CDC and state, local, and tribal health departments across the country. IT investments create the framework and systems necessary to monitor and track outbreaks, epidemics, and pandemics. 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:

- The Public Health Information Network (PHIN): Laboratory Response Network (LRN) Real Time Laboratory Information Exchange efforts equip LRN laboratories to share data securely with public health partners in real time to ensure the quality and availability of LRN data and decrease the time needed to detect and respond to public health threats.
- Epi Info™ is a suite of software tools for public health professionals for ad hoc data gathering, analytical needs, or as a rapid development environment for quickly programming public health focused outbreak and surveillance data applications.
- Public Health Laboratory Interoperability Solutions and Solution Architecture (PHLISSA) supports the Meaningful Use of EHRs through two-way communications between clinicians and national, state, and local public health entities.
- CDC WONDER, a web-based data dissemination system that provides statistical analysis, visualization, and reporting of CDC surveillance data available to public health professionals and the general public.
- The NVSS 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.
- National Health Interview Survey data are used to characterize the health level of the non-institutionalized U.S. population and a number of subgroups to address a wide range of health-related issues.

**STATE TABLE**<sup>1,2</sup>

<b>DEPARTMENT OF HEALTH AND HUMAN SERVICES (CENTERS FOR DISEASE CONTROL AND PREVENTION) FY 2013 DISCRETIONARY STATE/FORMULA GRANTS CFDA NUMBER: 93283 BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM</b>				
<b>STATE/TERRITORY</b>	<b>FY 2011 Appropriation</b>	<b>FY 2012 Enacted</b>	<b>FY 2013 President’s Budget</b>	<b>FY 2013 +/- FY 2012</b>
<b>Alabama</b>	\$166,373	\$166,373	\$166,373	0
<b>Alaska</b>	\$317,147	\$317,147	\$317,147	0
<b>Arizona</b>	\$272,871	\$272,871	\$272,871	0
<b>Arkansas</b>	\$289,386	\$289,386	\$289,386	0
<b>California</b>	\$282,621	\$282,621	\$282,621	0

<b>DEPARTMENT OF HEALTH AND HUMAN SERVICES (CENTERS FOR DISEASE CONTROL AND PREVENTION) FY 2013 DISCRETIONARY STATE/FORMULA GRANTS CFDA NUMBER: 93283 BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM</b>				
STATE/TERRITORY	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
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
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

<b>DEPARTMENT OF HEALTH AND HUMAN SERVICES (CENTERS FOR DISEASE CONTROL AND PREVENTION) FY 2013 DISCRETIONARY STATE/FORMULA GRANTS CFDA NUMBER: 93283 BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM</b>				
STATE/TERRITORY	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
<b>Vermont</b>	\$190,707	\$190,707	\$190,707	0
<b>Virginia</b>	\$206,347	\$206,347	\$206,347	0
<b>Washington</b>	\$292,434	\$292,434	\$292,434	0
<b>West Virginia</b>	\$272,646	\$272,646	\$272,646	0
<b>Wisconsin</b>	\$191,367	\$191,367	\$191,367	0
<b>Wyoming</b>	\$306,063	\$306,063	\$306,063	0
<b>State Sub-Total</b>	<b>\$12,225,002</b>	<b>\$12,225,002</b>	<b>\$12,225,002</b>	<b>0</b>
<b>America Samoa</b>	0	0	0	0
<b>Guam</b>	\$192,862	\$192,862	\$192,862	0
<b>Marshall Islands</b>	0	0	0	0
<b>Micronesia</b>	0	0	0	0
<b>Northern Marianas</b>	0	0	0	0
<b>Puerto Rico</b>	\$207,602	\$207,602	\$207,602	0
<b>Palau</b>	\$29,530	\$29,530	\$29,530	0
<b>Virgin Islands</b>	\$114,342	\$114,342	\$114,342	0
<b>Territory Sub-Total</b>	<b>\$544,336</b>	<b>\$544,336</b>	<b>\$544,336</b>	<b>0</b>
<b>Total States/Territories</b>	<b>\$12,769,338</b>	<b>\$12,769,338</b>	<b>\$12,769,338</b>	<b>0</b>

<sup>1</sup>Table does not include ACA/PPHF funding.

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