

**PUBLIC HEALTH SCIENTIFIC SERVICES**

(dollars in millions)	FY 2012 Enacted <sup>1</sup>	FY 2013 CR <sup>1,2</sup>	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	\$199.693	\$200.946	\$144.416	-\$55.277
PHS Evaluation Transfer	\$247.769	\$249.286	\$324.889	+\$77.120
ACA/PPHF	\$70.000	N/A	\$70.000	\$0.000
<b>Total</b>	<b>\$517.462</b>	<b>\$450.232</b>	<b>\$539.305</b>	<b>+\$21.843</b>
FTEs	1,069	1,066	1,066	-3

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

<sup>2</sup>The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

**Enabling Legislation Citation:** PHS Title II §§ 241, 301, 304, 306\*, 307, 308(d), 310, 317, 317G, 318, 319, 319A, 353, 391, 399V, 778, 1102, Title XVII\*, 2315, 2341, 2521\*; P.L. 107-347, Title V (44 U.S.C. 3501 note); Intelligence Reform and Terrorism Prevention Act of 2004 § 7211\* (P.L. 108-458); Food, Conservation, And Energy Act of 2008 § 4403 (7 U.S.C. 5311a); P.L. 101-445 § 5341 (7 U.S.C. 5341); The Patient Protection and Affordable Care Act of 2010 (P.L. 111-148)

**Enabling Legislation Status:** Permanent

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

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

**SUMMARY**

CDC's FY 2014 request of \$539,305,000 for Public Health Scientific Services, including \$70,000,000 from the Affordable Care Act Prevention and Public Health Fund, is an overall increase of \$21,843,000 above the FY 2012 level. This increase allows CDC to expand death data from the vital registration jurisdictions. The increase will also support development and implementation of new sample designs for population-based surveys following the 2010 Census, as well as improvements and expansions of data collection methods.

(dollars in millions)	FY 2012 Enacted <sup>1</sup>	FY 2013 CR <sup>1,2</sup>	FY 2014 President's Budget	FY 2014 +/- FY 2012
Health Statistics	\$159.062	\$160.036	\$181.475	+\$22.413
Surveillance, Epidemiology, and Public Health Informatics	\$246.712	\$248.253	\$245.799	-\$0.913
Public Health Workforce and Career Development	\$41.688	\$41.943	\$42.031	+\$0.343
ACA/PPHF	\$70.000	N/A	\$70.000	\$0.000
Public Health Research (non-add)	\$0.000	\$0.000	\$5.000	+\$5.000
<b>Total</b>	<b>\$517.462</b>	<b>\$450.232</b>	<b>\$539.305</b>	<b>+\$21.843</b>

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

<sup>2</sup>The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

Public health scientific services are the foundation of CDC's efforts to protect the U.S. public's health by supporting CDC's goal of monitoring health and ensuring laboratory excellence. These services lead the development, adoption, and integration of sound public health surveillance and epidemiological practices, and are based on advances in epidemiology, informatics, laboratory science, and surveillance. Investment at the local, state, and national levels is essential to create a public health system in which limited resources can be used most effectively; interventions can be targeted to those most in need; and public

health programs can be well-designed. Public health scientific services support efforts across the agency through five main components: (1) health statistics; (2) laboratory science, policy, and practice; (3) surveillance and informatics; (4) epidemiology and analysis; and (5) professional development.

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

Fiscal Year	Dollars (in millions)
2009	N/A
2010	\$408.351
2010 (ACA/PPHF)	\$32.358
2011	\$395.564
2011 (ACA/PPHF)	\$72.000
2012	\$447.462
2012 (ACA/PPHF)	\$70.000
2013	\$450.232
2013 (ACA/PPHF) <sup>2</sup>	N/A

<sup>1</sup>The FY 2012 and FY 2013 amounts are comparable to FY 2014 to reflect BSS realignment estimates.

<sup>2</sup>The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

**HEALTH STATISTICS BUDGET REQUEST**

(dollars in millions)	FY 2012 Enacted <sup>1</sup>	FY 2013 CR <sup>1</sup>	FY 2014 President's Budget	FY 2014 +/- FY 2012
<b>PHS Evaluation Transfer</b>	<b>\$159.062</b>	<b>\$160.036</b>	<b>\$181.475</b>	<b>+\$22.413</b>

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

**Program Overview:** The National Center for Health Statistics (NCHS) is a designated Federal Statistics Agency and the nation’s principal health statistics agency, and as such, is accepted as providing impartial and trustworthy information. NCHS collects data on births and deaths, health status, and healthcare through four main mechanisms: the National Health Care Surveys, the National Health Interview Survey (NHIS), the National Health and Nutrition Examination Survey (NHANES), and the National Vital Statistics System (NVSS).

NHIS, the principal source of information on the health of the civilian, non-institutionalized population of the United States since 1957, has added key content to monitor changes in health and healthcare. HHS uses NHIS data to monitor trends in illness and disability, and to track progress toward achieving national health objectives as outlined in *Healthy People* from 1990 to 2020.

NHANES is a population-based survey designed to collect information on the health and nutrition of the U.S. household population. Since the early 1960s, NHANES data have been used to inform policy and improve the health of the U.S. population in many ways. Examples include removing lead from gasoline, creating the pediatric growth charts, and establishing national baseline estimates for cholesterol, blood pressure, and Hepatitis C in the United States.

The National Health Care Surveys provide information about the organizations and providers that supply healthcare, the services rendered, and the patients they serve to study healthcare use, patient care quality, clinical management of specific conditions, disparities in use and quality of care, diffusion of healthcare technologies, and policy change effects. NCHS has conducted a major redesign of the healthcare surveys included integrating multiple surveys into the new National Health Care Survey (NHCS).

NVSS, the oldest and most successful example of inter-governmental data sharing in public health, is the mechanism by which NCHS collects vital records, through contract, from 57 vital registration jurisdictions to create the nation's official vital statistics. This partnership allows NCHS to document

emerging trends such as the increase in prescription drug-related deaths and the decrease in teen births. . NVSS is the source of information that the United States reports to the United Nations Statistics Division and the World Health Organization. The U.S. Census Bureau relies on information from the NVSS on births and deaths to create yearly population estimates used by state and local governments and to allocate funding.

Budget Proposal: CDC's FY 2014 request of \$181,475,000 for health statistics is an increase of \$22,413,000 above the FY 2012 level. The increase prioritizes and supports the expansion of vital statistics to gradually phase in electronic death records in the 21 remaining jurisdictions over four years. The increase will also support development and implementation of new sample designs for population-based surveys following the 2010 Census, as well as improvements and expansions of data collection methods. This investment will expand CDC's capability to monitor key health indicators at the national, state, and community level.

The FY 2014 budget request maintains NCHS's capacity to support its ongoing seminal health and healthcare surveys and data collection systems in FY 2014, using personal interviews, healthcare records, physical examinations, diagnostic procedures, lab tests, and vital event registrations. The Budget also allows CDC to purchase 12 months of birth and death data from the vital registration jurisdictions and to fully implement electronic birth records in the two remaining jurisdictions.

### ***National Health Care Survey***

In 2011, NCHS replaced the National Hospital Discharge Survey with the National Health Care Survey (NHCS). In FY 2014, NHCS will continue to obtain information on inpatient discharges but will expand the information obtained on the characteristics of the hospital, and will rely more on administrative data for information on inpatient stays. In addition, the sampled hospitals will provide data on visits to their emergency and outpatient departments, and ambulatory surgery locations. NCHS will also collect data from a new sample of freestanding ambulatory surgery centers. Data collected by the Drug Abuse Warning Network survey, previously conducted by the Substance Abuse and Mental Health Services Administration, will be obtained from the emergency department component of NHCS.

In FY 2014, NCHS will release the first data from the National Study of Long-Term Care Providers, which will provide nationally representative statistical information about the supply and use of paid, regulated, long-term care providers, including for the first time, data on care received and provided in Adult Day Care Centers.

### ***National Health Interview Survey***

To improve monitoring the effects of health initiatives, NCHS expanded the sample size of the NHIS in FY 2011 and FY 2012, improving precision of national estimates and doubling the number of states for which we have key data. Data for approximately 40 states are now available to monitor the impact of changes in health and healthcare in order to evaluate, target, and improve programs to keep Americans safe and healthy. In FY 2014, NCHS will launch a web-based follow-back where previous NHIS participants are contacted to track changes in their health behaviors resulting from the Affordable Care Act (ACA) changes in access to health services. NCHS plans to pilot test procedures that would allow for collection of biomeasures such as height, weight, and blood pressure. NCHS will test collection of dried blood spots as part of the household interview, as a means of capturing clinical level data on heart disease, stroke, and diabetes risk.

### ***National Health and Nutrition Examination Survey***

NCHS implemented the NHANES Youth Fitness Survey in 2012, collecting the first national data on physical activity levels of children and teens in the United States. Results from this study will help researchers and policymakers better understand factors affecting childhood obesity. The 2013–2014 NHANES will increase focus on tooth fluorosis and exposure to fluoride in children, including specially

enhanced digital photography and measures of fluoride in the blood and from the participant's water supply. In addition, NHANES will provide the first measurement of current human papillomavirus (HPV) infection in males on a national survey.

### ***National Vital Statistics System***

In FY 2014, NCHS will phase in full implementation of electronic death records, moving as many jurisdictions as possible (initial target 15–17 states) from outdated systems. The web-based systems will integrate with other public health information systems, allowing improved data quality and more rapid compilation and use of these critical data sources. NCHS will work with the remaining vital registration jurisdictions to implement electronic birth record systems and the 2003 revision of the U.S. Standard Birth Certificate. Vital registration data purchased for NVSS will provide complete and ongoing data of births and deaths.

### ***Survey Design, Data Analysis and Dissemination***

In FY 2014, NCHS will evaluate and improve its processes for collecting data through the Questionnaire Design Research Laboratory, a laboratory that develops and tests survey instruments, improving the quality and usefulness of federal statistics by improving the reliability and validity of health statistics survey instruments.

In order to facilitate access to NCHS data for as wide a range of users as possible, NCHS is developing access tools that allow users to more easily obtain analytic results of interest without using statistical software. These systems will allow users to promptly access data needed for research and decision-making. The first of these systems is an on-line data query system that allows users to access public use data from the National Hospital Ambulatory Medical Care Survey (NHAMCS) Emergency Department component. After completing the pilot test, NCHS will release a beta test version in FY 2013. If successful, NCHS will add data from the Outpatient Department component of the NHAMCS and from physician offices from the National Ambulatory Medical Care Survey over the next year. A second tool under development in FY 2014 will allow users to access both public use data as well as data that cannot be released due to confidentiality constraints (notably state identifiers) from the National Health Interview Survey. This on-line system will include state-of-the-art methods to ensure that respondent confidentiality is protected as required by law. Users will perform selected analyses of the rich multivariate NHIS core data from 1997 to the present in real time at no charge. In particular, they will be able to produce selected state-level estimates, addressing the need for more data at the state level for public health planning and evaluation.

NCHS conducts statistical research on small-area estimation. Most NCHS surveys provide data at the national, regional, or state level. There is growing interest among public health officials in obtaining information for smaller geographic areas, but it is not possible to produce estimates of sufficient reliability for these areas. Statistical models and auxiliary data can be used to produce better estimates (small-area estimates) for the areas of interest. In FY 2014, NCHS will continue to develop and evaluate models for small-area estimation, methods for incorporating auxiliary data, and methods for determining in advance whether a characteristic of interest would benefit from the application of “small-area estimation” techniques. Improved methods for small-area estimation will enhance the availability of state and local level data for planning and evaluation of public health efforts.

NCHS will continue to support data access and dissemination by making data more easily accessible to health professionals, researchers and policy makers. *Health, United States*, the Secretary's yearly report to Congress on the health of the nation, provides a timely overview of health, healthcare, and health insurance information to researchers, public health professionals, and policymakers. The Research Data Center provides access to confidential aggregate NCHS data, allowing researchers to conduct analyses that build on information presented in standard health statistics reports. NCHS will continue to improve the usability of data through the development of tools such as tutorials and on-line access systems, which

are made available to the public on the NCHS website. For example, NHANES is completing the tutorial on *NHANES-CMS* linked data (by August 2012), and plans to finish the *Physical Activity and Cardiovascular* fitness tutorial in 2013.

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

(dollars in millions)	FY 2012 Enacted <sup>1</sup>	FY 2013 CR <sup>1,2</sup>	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	\$137.626	\$138.499	\$102.385	-\$35.241
PHS Evaluation Transfer	\$109.086	\$109.754	\$143.414	+\$34.328
ACA/PPHF	\$45.000	N/A	\$45.000	\$0.000
Public Health Research (non-add)	\$0.000	\$0.000	\$5.000	+\$5.000
<b>Total</b>	<b>\$291.712</b>	<b>\$248.253</b>	<b>\$290.799</b>	<b>-\$0.913</b>

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

<sup>2</sup>The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

**Program Overview:** CDC’s public health scientific support services provide expertise in surveillance systems, epidemiologic analysis, informatics, public health workforce development, and laboratory policy and practice. CDC advances surveillance science and practice by managing various surveillance systems used across CDC, such as the Behavioral Risk Factor Surveillance System (BRFSS) and the National Notifiable Diseases Surveillance System (NNDSS) and by establishing and sharing best practices that can be used by CDC programs and the public health community. Protecting and promoting public health requires reliable, timely, and constant information; CDC's informatics program supports public health surveillance by bridging the gap between the changing world of information technology and electronic health information with the public health community. CDC advances these efforts through supporting the adoption of Electronic Health Records-Meaningful Use (EHR-MU); deploying an innovative applied public health informatics laboratory and research cloud; and providing data management and information exchange services to CDC programs and the public health community. CDC provides expertise in scientific publication and systematic reviews to establish the evidence base for interventions. CDC puts epidemiology to work with products and services such as the *Morbidity and Mortality Weekly Report (MMWR)*, *CDC Vital Signs*, the *Guide to Community Preventive Services*, Epi Info™ and *Science Clips*. CDC’s laboratory science, policy, and practice program provides leadership and training services to strengthen the quality of laboratory science at CDC, in the United States, and globally by providing guidelines and recommendations for public health laboratories. These services support CDC’s national efforts to promote health; prevent disease, injury and disability; and prepare for emerging health threats.

***Behavioral Risk Factor Surveillance System (BRFSS)***

CDC’s BRFSS was developed in 1984 and is the world’s largest ongoing telephone health survey system. Every year, 50 states and seven territories work with CDC to design customized BRFSS questionnaires and collect and process data from adults on the health status, preventive health practices, and health risk behaviors associated with many of the most costly chronic conditions. These conditions—such as diabetes, high blood pressure, and cancer—are among the leading causes of death and disability in the United States. Flexibility in the BRFSS questionnaire design accommodates changing priorities, as well as public health emergencies, making it an optimal choice for gathering state-specific information such as the misuse of opioid prescription drugs in Utah and Montana, or information on national issues such as healthcare reform. Because the BRFSS is a state-based rather than national surveillance system, it is in a unique position to provide data specific to every state as well as community-level data for over 150 metropolitan statistical areas (MSAs) and the counties within those MSAs. Community data are essential for health departments to develop targeted public health interventions, address health disparities within their states, and allocate resources more efficiently. For many states and localities, the BRFSS is the only

source for this type of timely information. CDC programs, policymakers, and health researchers also rely on BRFSS data to track health trends and inform the development and evaluation of public health programs and policies to improve health.

### ***National Notifiable Diseases Surveillance System (NNDSS)***

In operation since 1951, CDC's NNDSS is the only public health surveillance system that monitors nationally reported cases of diseases posing the greatest threat to human health, including those that are of bioterrorism concern, including anthrax, botulism, plague, and smallpox, among others. The NNDSS also monitors many other foodborne, waterborne, and airborne diseases. In total, NNDSS monitors 77 nationally notifiable diseases for CDC programs through a centralized national system. Rather than conducting surveillance separately for each disease, states use NNDSS to report these diseases to CDC. To this end, CDC currently provides direct assistance to 50 states, eight territories, and five large local health departments through cooperative agreements. CDC sends approximately 50 percent of the NNDSS program funds to the jurisdictions to improve their ability to conduct these surveillance activities. The other 50 percent is used to provide oversight and standards development or national data management and technology improvements for public health reporting. Currently within a day of diagnosis, jurisdictions can notify the CDC Emergency Operations Center of disease cases. Regional and national notifiable disease data also are available to states for their disease prevention and control efforts. Within CDC, the NNDSS program provides disease-specific data to programs whose job is to identify and monitor disease outbreaks, develop policies and public health programs to prevent and control the spread of disease, and to evaluate the effectiveness of those interventions on a national level. Through new technical approaches, the NNDSS aims to improve the accessibility and usability of notifiable disease data for public health program planning and evaluation. Enhancing the timeliness of data and efficiencies in surveillance operations at local, state, and national levels is an additional goal. Success will be evident as the overall utility of notifiable diseases data for local and state health agencies and national public health programs increases.

### ***Epidemiology***

CDC collaborates with state and local public health partners to create and promote high quality, timely, and useful scientific products and services to strengthen and improve public health science and decision-making. These crosscutting products and services include: *Morbidity and Mortality Weekly Report*; *CDC Vital Signs*, systematic review methodology for the *Guide to Community Preventive Services* (Community Guide); innovative methods to collect, analyze, and communicate public health surveillance information through Epi Info™ software; analytic methods development; and access to scientific literature through the Public Health Library and Information Center and *Science Clips*.

CDC and public health partners employ the scientific products and services to inform decisions affecting public health. For example, the Community Guide builds the scientific evidence base for recommendations of an independent Task Force by conducting systematic reviews to address significant high-priority public health problems such as obesity, emergency preparedness, tobacco use, and worksite health promotion. The recommendations empower decision makers to optimize resources to: (1) protect and improve health, (2) reduce demand for future healthcare spending driven by preventable disease and disability, and (3) increase the U.S. workforce's productivity and economic competitiveness. The *MMWR* reports events of public health importance and prevention strategies to state and local health departments as quickly as possible to inform public health decision-making. *CDC Vital Signs*, a monthly feature including an *MMWR* report and supporting multimedia materials, extends the reach of the *MMWR* data through TV, print, broadcast, and internet media to deliver critical health information to the general public. Epi Info™ provides essential, free software to domestic and international public health partners for rapid assessment of disease outbreaks, cost-effective surveillance and monitoring, and customization of community surveys and reports, and supports epidemiologic and analytic standards for best practices in outbreak investigations and surveillance.

## *Informatics*

Since its inception in 1997, CDC's informatics program has applied the powerful capabilities of information science and technology to help CDC programs prevent disease, disability, and early death. Program goals are: (1) strengthening the ability of public health agencies to benefit from and manage advances in electronic health information; and (2) fostering innovation, identifying best practices, sharing knowledge, and serving as the primary resource for issues in public health informatics. Through this program, CDC translates public health needs into information processes that are valued, strategic, and consistent with the larger health information technology (IT) world. This involves processing approximately 1.5 billion electronic messages exchanging public health information per year on behalf of CDC programs and state health departments. Informatics-based solutions improve public health information exchange in the areas of surveillance, emergency preparedness, laboratory services, and other public health activities. CDC strives to improve electronic data exchange across organizational and jurisdictional boundaries among state and local health departments and CDC programs.

The CDC informatics program supports the national "Electronic Health Records-Meaningful Use" (EHR-MU) initiative by engaging public health partners at federal, state, and local levels, as well as across CDC programs. CDC engages with federal partners to support the public health components of the electronic exchange of health information to improve the quality of care. Within CDC, the informatics program works closely with immunization services and the Epidemiology and Laboratory Capacity programs to prepare grantees to meet "Meaningful Use" requirements. Further, CDC provides direct assistance to state public health agencies to support electronic health information systems that receive data from providers: (1) reportable laboratory results, (2) immunization data submitted to immunization registries or immunization information systems, and (3) syndromic surveillance data. Success is measured by the number of public health agencies that are capable of accepting this information electronically. As of June 30, 2012, 48 out of 50 state health departments are capable of receiving meaningful use immunization data. In addition, 85 percent of jurisdictions (44 States and two local jurisdictions) can receive immunization data from the immunization registry.

CDC also supports the applied public health informatics laboratory and research cloud, which is a new service that significantly improves the evaluation and use of technology. The laboratory applies novel informatics techniques to further develop new informatics technology, and works with the appropriate CDC programs for deployment and implementation into public health programs. Recently, the lab improved physician decision-making capabilities through a new smartphone application, "PTT Advisor," which provides clinical guidelines and recommendations to physicians at the point of care, at no cost to them, related to an abnormal partial thromboplastin time (PTT) laboratory result. The program's success is defined by annual growth in the number of CDC programs and projects using this service application. The public health laboratory provides a frequently used service that displays success by monitoring the continual growth of CDC program engagement in the exploration of new techniques and solutions.

CDC supports a variety of surveillance systems and health information technology initiatives, including NNDSS, BioSense 2.0, electronic laboratory reporting, immunization reporting, and unstructured data (i.e. social media, etc.). Support includes providing data management information exchange support, data analysis tools, and other services as deemed necessary by CDC and the public health community. To explore the expansion of this support, CDC is creating a public health platform that engages members at all levels of the public health community to develop a useful and sustainable environment. Using an innovative design, this public health platform will support analytic tools and data services crucial to assisting public health officials in decision-making at the state and local level. This public health platform is housed in one environment, while integrating multiple programs and software platforms to increase utility and reduce redundancy in public health surveillance systems. The public health platform development is iterative and agile, allowing it to be flexible to meet the ever-changing needs of CDC and the public health community, and accommodate new advances in health information technology, surveillance, and public health practices.

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

CDC's laboratory science, policy, and practice program strengthens state and local public health laboratories' ability to perform their critical role in protecting the public's health. The program helps public health laboratory leaders and professionals by developing and providing science-based recommendations for best practices and higher efficiency; creating a national database of public health laboratories' test services to encourage sharing of services across states; and delivering training in cutting-edge testing methods to thousands of public health laboratory professionals each year, both in laboratories and using distance-based methods. Within CDC, the program coordinates development of policies for CDC laboratories. One example is the Select Agents and Toxins Compliance Policy, the first uniform policy for possession, use, and transfer of dangerous select agents and toxins for all CDC laboratories in the United States. The program also delivers training and consultation to assist CDC laboratories to comply with federal regulatory mandates related to select agents, scientific specimen collections, and dual-use research.

In addition, CDC serves the nation's more than 230,000 clinical laboratories by working with the Centers for Medicare and Medicaid Services (CMS), through an interagency agreement, to develop science-based regulatory standards. Through this collaborative effort, the agencies conduct quality improvement research to assure the accuracy and reliability of clinical laboratory testing. Recently, the American Society for Microbiologists adopted CDC methods for systematic evidence reviews of laboratory quality improvement practices. CDC also contributes to the development of voluntary practice standards and guidelines to improve laboratory testing in support of quality healthcare. In addition, CDC develops and distributes companion educational products to improve practitioners' understanding and use of laboratory standards and guidelines.

Budget Proposal: CDC's FY 2014 request of \$290,799,000 for surveillance, epidemiology, informatics, and laboratory science, including \$143,414,000 in Public Health Service (PHS) Evaluation Transfer funds and \$45,000,000 from the Affordable Care Act Prevention and Public Health Fund is a decrease of \$913,000 below the FY 2012 level. The budget request maintains CDC's capacity to support the ongoing quality, timeliness, and accessibility of public health data for decision-making; support development of methods to improve quality; and support access to information from electronic health records. The FY 2014 Budget includes \$5,000,000 for public health systems research as authorized by Section 4301 of the Affordable Care Act. CDC will undertake research that seeks to identify the economic and budgetary impacts of public health interventions; expand data on healthcare utilization and effectiveness; and inform how public health should evolve and public health and healthcare should collaborate as the healthcare delivery system transforms.

### ***Behavioral Risk Factor Surveillance System (BRFSS)***

In FY 2014, CDC will fund states to improve population coverage of the BRFSS by increasing the average percentage of completed cell phone interviews to 25 percent. CDC will continue to explore the use of innovative, cost-effective ways to administer the BRFSS questionnaire—such as the use of internet-based panel surveys—to access hard-to-reach populations. The provision of community-level data will continue to be a priority in FY 2014, as CDC will utilize small area estimation modeling techniques to produce BRFSS estimates for every county in the United States. CDC will improve access to analytic tools to increase utility among BRFSS data users. These activities will build upon the recent successes of the BRFSS. For example, recently, CDC released the first BRFSS data set that combined data from both landline and cellular telephone survey respondents using a new advanced statistical weighting method. By including data from the adult population with only a cell phone and no landline phone (about 30 percent of all adults nationwide), BRFSS estimates now better capture health-risk behaviors and chronic disease prevalence among adults, especially among younger and lower-income adults who were previously under-represented in the BRFSS. Two new pilot projects that will test novel data collection methods are currently in their early stages. One of these innovative pilots will examine the

feasibility of collecting self-reported health data using electronic tools and comparing the reported data with the respondent's electronic health record data. CDC will use the results of these pilots, as well as a recent evaluation of BRFSS, to ensure the BRFSS is maintained as a timely, efficient, and agile state-of-the-art surveillance system.

### ***National Notifiable Diseases Surveillance System (NNDSS)***

In FY 2014, CDC's NNDSS will continue to fund 50 states, seven territories, Washington, D.C and five large health departments to improve their ability to identify and monitor disease outbreaks, develop policies and public health programs to prevent and control the spread of disease, and to evaluate the effectiveness of those interventions within their states. For example, CDC support of NNDSS allowed Washington, D.C. to efficiently manage cases for people who lived, worked or used providers in other states within the greater metropolitan area, which improved the accuracy of reporting for Maryland, Washington, D.C. and Virginia. CDC continues to focus on improving efficiency of technology by completing a two-part evaluation of NNDSS. Phase I, completed December 2011, focused on CDC stakeholders who process, validate, and use NNDSS data. Phase II, launched at a public health conference in June 2012, focused on state-level users. On the basis of the evaluation results so far, CDC made further data-quality improvements and increased data processing efficiency. Reporting will be easier by adopting more intuitive visual displays. Interactive systems will allow users, both at CDC and at state and local levels, to use their own data to create need-specific charts, maps, and trend lines. In FY 2014, CDC will continue to make recommended improvements to data quality and completeness, and provide users with better visual analysis tools.

### ***Epidemiology***

In FY 2014, CDC will extend the readership of MMWR and CDC Vital Signs by partnering with constituents in state and local health departments; international colleagues; clinical medicine counterparts; print, broadcast, and online media; to make both publications more readily available through current and emerging technology in academic, research, and clinical settings. In FY 2012, CDC provided high quality, timely and useful scientific products and services to strengthen and improve public health science and decision-making. The Public Health Library and Information Center use in key areas such as article downloads, literature searches, reference questions, and training increased from 28 to 54 percent from FY 2011 levels, depending on the service. In the last six months of FY 2012 alone, *MMWR* published over 150 reports and summaries, and increased electronic subscribers by 20 percent. The *CDC Vital Signs* reached more than 1.8 million communication channels through [www.cdc.gov/vitalsigns](http://www.cdc.gov/vitalsigns), social media, and subscribers to CDC information subscriptions services.

In FY 2014, CDC will continue to provide administrative, research and technical support to the Community Preventive Services Task Force. CDC provided scientific input to the Task Force in developing recommendations regarding tobacco use, skin cancer, health equity, alcohol and motor vehicle-related injury; provided technical assistance to seven states to increase awareness and use of the Guide; and increased by 125 percent the number of people receiving updates through GovDelivery e-mail service in the last six months of FY 2012. Across the nation, communities will continue to use recommendations to improve health and save money; for example, the Mount Prospect, Illinois school system saved \$66,657 annually on busing and doubled the number of students walking to school after implementing Task Force-recommended "street-scale infrastructure improvements" (e.g. sidewalks, marked crossings) to increase student activity levels.

In FY 2012, CDC released Epi Info™ version 7.1, an update with new mobile and web survey components; conducted 15 instructor-led training courses to 370 participants through collaboration with various public health partners; provided training to 81 new EIS officers; and conducted 15 Epi Info™ demonstrations for various public health partners. In FY 2014, CDC will continue these activities and expand efforts to maximize the impact of Epi Info™, including providing 20 demonstrations and 21 instructor-led training courses to various public health partners. In addition, CDC will maximize the

impact of Epi Info™ by developing special studies and investigations for domestic and international partners, and customer-requested services that allow access via handheld devices and the internet.

### ***Informatics***

In FY 2014, CDC will increase the public health usability of Electronic Health Records–Meaningful Use (EHR-MU), automated laboratory information systems, and health information exchanges by developing standard informatics guidelines and tools in collaboration with other CDC programs. These standards will streamline important public health activities such as emergency outbreak alerting, laboratory science practices, and clinician decision support. Current accomplishments include CDC’s pilot project with Chicago Department of Public Health and a network of Chicago Community Health Centers to deliver electronic public health outbreak alerts through electronic medical record (EMR) systems to clinicians. The alerts allow clinicians to react more quickly and effectively against a public health threat, by utilizing CDC-provided clinical guidelines and patient education information.

CDC informatics efforts will improve and increase the quality and quantity of data it provides to public health officials for interventions and decision-making. CDC will also identify and assist with public health needs in the field by providing the policies, analytic tools, data management tools, and other useful services to state and local partners, other federal agencies and organizations within CDC. In FY 2014, CDC will continue to explore innovative technology options using the applied public health informatics laboratory and research cloud. Since FY 2011, the laboratory has tested and supported 55 projects, representing 25 CDC programs. With level funding, the public health informatics laboratory plans to have an additional 31 engagements with 20 programs in FY 2014.

CDC will continue developing a public health platform that will enhance the mechanisms of collecting, processing, analyzing, and disseminating collected electronic health data. The platform will serve current and future public health needs, and will be designed with the potential to easily accommodate ever-changing technology.

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

In FY 2014, CDC will implement new agency-wide policies for specimen collection management and ensure that CDC laboratories, which work with select agents and toxins, comply with federal regulatory requirements. In FY 2011, CDC developed and adopted the new Select Agents and Toxins Compliance Policy, the first uniform policy for possession, use, and transfer of dangerous select agents and toxins for all CDC laboratories in the United States. CDC also managed a unique and invaluable repository of biological specimens for use by researchers.

CDC will also ensure and track CDC compliance with federal dual-use research of concern requirements, and implement its five-year technology transfer plan. In FY 2012, CDC developed the first-ever, five-year plan to intensify and accelerate the commercialization of inventions developed by CDC laboratory scientists. This will lead to rapid translation of CDC scientific findings into new diagnostic tests, vaccines, and other products that public health departments and healthcare providers will use to prevent disease, identify disease cases, and treat patients.

CDC will create additional practical resources and provide scientific and programmatic expertise in FY 2014 to improve public health laboratories’ efficiency, effectiveness, and sustainability. Public health laboratories provide support to the nation’s health preparedness efforts. In FY 2012, CDC and partners launched the Laboratory Efficiencies Initiative (LEI) to help public health laboratories maintain critical testing protocols and build long-term sustainability. CDC implements high-efficiency management practices such as sharing test services among states, standardizing testing platforms, adopting interoperable informatics systems, and reducing procurement costs. Among other practical achievements, CDC led development and national dissemination of an evidence-based guide that laboratory directors can use to assess and plan implementation of such practices.

CDC will develop and deliver a minimum of 60 training courses in advanced public health laboratory practice to state and local public health professionals. Training needs assessments show there will be a large exodus of experienced staff from public health laboratories by 2020. New entrants into the public health laboratory workforce will require extensive training in basic, intermediate, and advanced microbiology; in molecular biology skills; and in such overarching skillsets as biosafety, biosecurity, and quality management systems. CDC will develop a new curriculum on core laboratory skills to address this critical need. In FY 2012, CDC conducted more than 96 training courses, reaching more than 6,000 laboratory professionals on topics such as biosecurity and biosafety best practices, influenza testing, tuberculosis, vaccine-preventable diseases, newborn screening, and parasitology. Evaluations from the training workshops indicated that: (1) 58 percent of training course participants implemented new or modified testing protocols and (2) 63 percent of the public health and clinical laboratory professionals who participated in training workshops will improve their laboratories' policies or practices.

Grant Tables:

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

(dollars in millions)	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget
Number of Awards	57	57	57
Average Award	\$0.247	\$0.247	\$0.247
Range of Awards	\$0.048–\$0.458	\$0.048–\$0.458	\$0.048–\$0.458
Number of New Awards <sup>2</sup>	2	0	0
Number of Continuing Awards	55	57	57
<b>Total Grant Award</b>	<b>\$14.100</b>	<b>\$14.100</b>	<b>\$14.100</b>

<sup>1</sup>The BRFSS was funded through budget authority, Public Health Service evaluation funds, funding from other CDC programs, and Prevention and Public Health Fund (PPHF) dollars in FY 2012. Non-core funding from other CDC programs and PPHF dollars are not reflected in this table.

<sup>2</sup>In FY 2011, two new territories joined the BRFSS, bringing the total to 57 grantees.

CDC works in partnership with state and territorial health departments through cooperative agreements to administer the BRFSS. Grant awards are based primarily on the required sample size needed in the state to produce reliable estimates, the type of data collector used by the state (i.e., in-house, university, or private company), and special projects (e.g., mail and web pilots, call-back surveys, etc.). In FY 2014, CDC will fund 57 grantees to complete approximately 500,000 BRFSS surveys.

***National Notifiable Diseases Surveillance System (NNDSS) Grant Table***

(dollars in millions)	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget
Number of Awards	63	64	64
Average Award	\$0.163	\$0.162	\$0.162
Range of Awards	\$0.010–\$0.373	\$0.010–\$0.373	\$0.010–\$0.373
Number of New Awards <sup>1</sup>	7	1	1
Number of Continuing Awards	56	64	64
<b>Total Grant Award</b>	<b>\$10.343</b>	<b>\$10.659</b>	<b>\$10.259</b>

<sup>1</sup>New funding opportunity announcement was recompeted in FY 2012.

In FY 2012, the beginning of a new five-year cooperative agreement period, all 50 states, five large local health departments, the Commonwealth of Puerto Rico, Washington D.C., and an additional six United States Affiliated Pacific Island territories were funded. These cooperative agreement awards are competitive, based on grantee request, and subject to the availability of funds. In FY 2013, the U.S. Virgin Islands will begin to receive funding for electronic disease reporting. CDC's NNDSS funding provides local and state public health agencies with the means to track, report, and respond to notifiable diseases. Funding is used to assist states to increase capacity (i.e. IT upgrades, personnel etc.) to provide

notifiable disease information to CDC in a timely manner. Because diseases do not respect borders, every major country in the world has a nationally notifiable disease surveillance system.

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

(dollars in millions)	FY 2012 Enacted <sup>1</sup>	FY 2013 CR <sup>1,2</sup>	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	\$41.688	\$41.943	\$42.031	+\$0.343
ACA/PPHF	\$25.000	N/A	\$25.000	\$0.000
<b>Total</b>	<b>\$66.688</b>	<b>\$41.943</b>	<b>\$67.031</b>	<b>+\$0.343</b>

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

<sup>2</sup>The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

**Program Overview:** A well-trained public health workforce is critical to ensuring the highest level of efficiency and effectiveness in protecting population health—a responsibility that only public health systems ensure. CDC ensures a prepared, diverse, and sustainable public health workforce through programs that recruit new talent through experiential fellowships and provide high-quality workplace training, including e-learning. CDC’s fellowships and student programs develop skilled public health workers, serve state and local health departments, and fill gaps in key public health areas. CDC's fellowships include: (1) Epidemic Intelligence Service (EIS), (2) Presidential Management Fellows Program, (3) Prevention Effectiveness Fellowship Program, (4) Preventive Medicine Residency/Fellowship, (5) Public Health Associate Program, (6) Public Health Informatics Fellowship Program, and (7) Public Health Prevention Service (PHPS). CDC fellows provide a range of services to global, federal, state, tribal, local, and territorial partners. Fellows provide critical assistance with ongoing public health challenges, such as foodborne outbreak responses, reducing healthcare-associated infections, obesity prevention, tobacco use reduction, and injury prevention,. Fellows also provide surge capacity during public health emergencies, such as natural disasters and outbreaks of influenza, polio, and cholera. Placement of some fellows in the field also fills critical public health workforce gaps throughout the country. In addition to bringing new talent into public health, CDC trains the current workforce. CDC's centralized learning management system, CDC TRAIN, is accessible to all members of the public to pursue e-learning on a wide range of public health topics.

**Budget Proposal:** CDC’s FY 2014 request of \$67,031,000 for Public Health Workforce and Career Development, including \$25,000,000 from the Affordable Care Act Prevention and Public Health Fund, is an increase of \$343,000 above the FY 2012 level.

As of September 30, 2012, CDC supported 546 fellows; 339 (62%) of those fellows were in state, tribal, local, and territorial field assignments in 45 states, Washington, D.C., American Samoa, Puerto Rico, and five tribal locations. The remaining fellows, 207 (38%), were assigned to CDC. CDC’s “disease detectives” from the Epidemic Intelligence Service (EIS) were on the ground early in the nationwide response to the 2012 fungal meningitis outbreak, playing a key role in extending CDC’s response and providing assistance to state and local public health officials. Over 80 EIS officers were marshaled for the response, providing critical assistance with identifying cases, tracking down and communicating with those exposed to the contaminated medication, and developing treatment guidelines for an infection rarely seen in humans. In FY 2014, CDC will maintain capacity to support fellowship programs, including EIS, which provide robust experiential learning while filling critical gaps in the public health workforce, and provide continuing education and training for the existing health professional workforce. In FY 2014, CDC will provide additional public health e-learning opportunities, enhance scientific and programmatic expertise provided by fellows, and increase its efforts to retain fellows in the public health system.

In FY 2014, CDC’s cooperative agreements with academic partners will initiate the placement of fellows in community-based public health assignments, while continuing to support approximately 17 fellows in

assignments at CDC. The cooperative agreements also will support the integration of population health concepts into curricula at medical, nursing, and public health schools.

Recognizing a need in the public health community, CDC is currently developing a new core curriculum for entry-level staff to enhance crosscutting skills in the basic public health sciences, including epidemiology, surveillance, informatics, prevention effectiveness, and laboratory practice. Since the launch of the CDC TRAIN learning management system in August 2011, over 36,000 learners have registered, giving them access to over 4,900 high-quality, technology-based learning products. In FY 2014, CDC plans to continue to expand access to public health e-learning products and training for the health professional workforce by including more learning products in CDC TRAIN, promoting the core public health curriculum, and connecting partner learning management systems.

CDC will reduce recruiting costs for its fellowships through social media; webinars; use of local, virtual career fairs; and videoconferencing. CDC will seek additional ways to achieve cost savings in the recruitment and training of fellows. CDC also will retain more fellowship graduates in state and local assignments through contracts, direct assistance, and increasing awareness of field assignment positions available across the agency.

Grant Table:

***Academic Partners Grant Table***

(dollars in millions)	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget
Number of Awards	4	4	4
Average Award	\$0.325	\$0.325	\$0.325
Range of Awards	\$0.265–\$0.385	\$0.265–\$0.385	\$0.265–\$0.385
Number of New Awards <sup>1</sup>	4	0	0
Number of Continuing Awards	0	4	4
<b>Total Grant Award<sup>2</sup></b>	<b>\$1.300</b>	<b>\$1.300</b>	<b>\$1.300</b>

<sup>1</sup>New funding opportunity announcement was recomputed in FY 2012.

<sup>2</sup>Total grant award represent the core award; other CDC offices can choose to fund supplemental awards using this cooperative agreement.

CDC funds four awardees through a competitive cooperative agreement program. The purpose of the cooperative agreement is to foster collaboration between academia and public health in order to make education more practical, and align academia with ground-level public health priorities as a strategy to improve population health. This cooperative agreement provides financial assistance for professional associations that represent domestic schools and programs that educate public health professionals, physicians, and nurses. The four awardees are the Association of American Medical Colleges, Association for Prevention Teaching and Research, Association of Schools of Public Health, and American Association of Colleges of Nursing. The collaborative facilitates interprofessional exchange and partnerships essential in enhancing professional education and improving public health. At the end of five years, awardees are expected to expand by 25 percent the number of medical and nursing schools that integrate population health concepts into their curriculum.

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

(dollars in millions)	FY 2012 Enacted <sup>1</sup>	FY 2013 CR <sup>1</sup>	FY 2014 President's Budget	FY 2014 +/- FY 2012
<b>ACA/PPHF</b>	<b>\$70.000</b>	<b>N/A</b>	<b>\$70.000</b>	<b>\$0.000</b>

<sup>1</sup>The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

The following activities are included:

- Healthcare Surveillance/Health Statistics – \$30,000,000

- Public Health Research - \$5,000,000
- Public Health Workforce Capacity – \$25,000,000 (included in the Public Health Workforce narrative)
- Community Guide – \$10,000,000

### ***Healthcare Surveillance/Health Statistics***

In FY 2014, CDC will target the \$30,000,000 request in Prevention and Public Health Fund investments toward tracking the effects of the Affordable Care Act on the healthcare system and on health outcomes. CDC will also direct \$5,000,000 for public health systems research as authorized by Section 4301 of the Affordable Care Act. The National Health Interview Survey (NHIS), National Ambulatory Medical Care Survey (NAMCS), and National Hospital Ambulatory Medical Care Survey (NHAMCS) are the core data systems used to monitor the effects of the Affordable Care Act. The NHIS will track the Affordable Care Act impact on care access and utilization. The increase in the NHIS sample will provide stable estimates for targeted populations. The NAMCS sample of physicians will expand to permit greater precision for estimates related to care that different population groups and groups with different conditions receive.

Surveys of ambulatory care through NAMCS, and hospital outpatient departments through NHAMCS, will expand the data collected on clinical management and on patient's risk factors for those with heart disease and stroke during the 12 months before the sampled visit. These data and resulting analysis will permit monitoring and evaluating goals to increase prevention through healthcare programs and expanded insurance coverage.

CDC will provide funding to the two states and territories that have not implemented the re-engineered, web-based electronic birth record systems and 2003 U.S. Standard Birth Certificate. Re-engineering the states' electronic infrastructure for registering birth and death certificates will improve the timeliness, quality, and security of the National Vital Statistics System. This will allow for faster reporting of birth data that is important to public health planning and evaluation. The computerization of birth as well as death certificates is crucial to improve security and effectively cross-match birth and death records to reduce birth certificate fraud. This funding will build on \$2,500,000 provided in FY 2012 to implement electronic birth record systems in four states.

CDC will use the Behavioral Risk Factor Surveillance System (BRFSS) to collect more detailed state-specific data for state- and sub-state adult populations on health insurance coverage, access to healthcare, and use of clinical preventive services than is currently available in the BRFSS. This funding will provide an additional year of data that state and local health departments can use to: (1) monitor the impacts of the Affordable Care Act on state healthcare access and utilization; and (2) evaluate the impacts of the Affordable Care Act on state prevalence estimates for diseases, health conditions, and risk behaviors associated with the leading causes of death and disability.

CDC will undertake research that seeks to identify the economic and budgetary impacts of public health interventions; expand data on healthcare utilization and effectiveness; and inform how public health should evolve and public health and healthcare should collaborate as the healthcare delivery system transforms.

### ***Community Guide***

The Community Preventive Services Task Force (Task Force) findings and recommendations identify programs, services, and policies proven effective in a variety of real-world settings, such as communities, worksites, schools, and health plans. Demand for Task Force findings and recommendations are stronger now than ever before. In FY 2014, CDC will continue to provide ongoing administrative, research, and technical support for the operations of the Task Force by:

- Increasing the number of Community Guide systematic reviews that support Task Force findings and recommendations to address high-priority public health needs and identifying evidence gaps.
- Building dissemination and implementation support to assist policymakers, practitioners, and other decision makers in accessing and using Task Force recommendations.
- Increasing efficiency of Task Force operations to include supporting Task Force and committee meetings and the Task Force Annual Report to Congress.

**PERFORMANCE**

***Program: Health Statistics***

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

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012
8.A.E.1: Reduce the number of months from the end of data collection to data release on the internet (Outcome; Efficiency)	FY 2010: 7.6 (Target Exceeded)	9.4	7.5	-1.9
8.A.1.1a: Sustain the percentage of NCHS website users that are satisfied with data quality and relevance (Outcome)	FY 2012: 77.4% (Target Exceeded)	75.2%	77.4%	+2.2
8.A.1.1b: Sustain the percentage of Federal Power Users (key federal officials involved in health and healthcare policy or programs) that indicate that data quality is good or excellent (Outcome)	FY 2012: 100% Good or Excellent (Target Met)	100% Good or Excellent	100% Good or Excellent	Maintain
8.A.1.3: Increase the number of web visits as a proxy for use of NCHS data <sup>1</sup> (Output)	FY 2012: 8.2 Million (Target Not Met)	8.5 Million	10.6 Million	+2.1
8.F: Number of communities visited by mobile examination centers from the National Health and Nutrition Examination Survey (Output)	FY 2012: 15 (Target Met)	15	15	Maintain
8.G: Number of households interviewed in the National Health Interview Survey <sup>2,3</sup> (Output)	FY 2012: 51,000 <sup>4</sup> (Target Exceeded)	46,500	55,000	+8,500
8.H.1: Number of physicians surveyed in the National Ambulatory Medical Care Survey <sup>2,3</sup> (Output)	FY 2012: 18,741 (Target Exceeded)	10,200	14,500	+4,300
8.H.2: Number of patient visit records surveyed in the National Ambulatory Medical Care Survey <sup>2,3</sup> (Output)	FY 2012: 170,543 (Target Exceeded)	90,000	132,000	+42,000

<sup>1</sup>For FY 2013 onward, targets and actual results reflect an improved method for calculating web visits.

<sup>2</sup>FY 2012 targets and results reflect ACA/PPHF funding.

<sup>3</sup>The increase in NHIS and NAMCS sample size will vary depending on when funds are received.

<sup>4</sup>This is an estimate. Final data will be available June 30, 2013.

Performance Trends: CDC uses several indicators to measure its ability to provide useful, timely and high quality data. CDC released FY 2010 data within 7.6 months of completing its data collection, exceeding the target and improving efficiency while maintaining data quality (Measure 8.A.E.1). To drive program improvements, CDC assesses user satisfaction. The percentage of National Center for Health Statistics' (NCHS) website users who are satisfied with data quality and relevance has increased by 10 percentage points since 2008 (Measure 8.A.1.1a). Similarly, in 2012 CDC interviewed Federal Power Users (key federal officials involved in health and healthcare policy or programs) to assess their satisfaction with CDC products and services including data quality, ease of data accessibility and use, professionalism of staff, relevance of data to major health issues, and relevance of data to user needs. CDC met the target of 100 percent Good or Excellent ratings for the fifth consecutive year in FY 2012 (Measure 8.A.1.1b). Finally, CDC tracks the number of web visits as a proxy for the use of NCHS data. Web visits to NCHS webpages within <http://www.cdc.gov> and texting subscribers decreased by 0.5 million in FY 2012 compared to 2010, although still up from 6.8 million in FY 2008 (Measure 8.A.1.3). A more accurate system for verifying web visits will be used beginning in FY 2013. CDC anticipates this system will reflect higher use of the NCHS web site than could be captured previously.

In addition to data quality, CDC also monitors the implementation of its national surveys. The number of communities visited by the mobile examination centers for the National Health and Nutrition Examination Survey remained stable at 15 (Measure 8.F). Since 2010, CDC has increased the number of interviews for two of its surveys. The sample size of the National Health Interview Survey increased by approximately 23 percent in FY 2012 compared to 2011 and 33 percent compared to 2010 (Measure 8.G). For the National Ambulatory Medical Care Survey, the number of physicians interviewed and patient records surveyed increased, by 367 percent and 414 percent, respectively over FY 2011 (Measures 8.H.1 and 8.H.2). The increases were due largely to funding received from the Prevention and Public Health Fund to monitor health reform efforts. Better data on expanded access to care, prevention, management of chronic conditions, and ultimately, improved health outcomes will result from the expansions. The Prevention and Public Health Funds for the National Ambulatory Medical Care Survey allowed for an increase in the sample; the timing of the receipt of those funds resulted in an even greater increase in the 2012 calendar year sample than had been anticipated. CDC anticipates the sample size will stabilize at a lower level in future survey years and has set the FY 2014 target accordingly. FY 2014 targets for the National Health Interview Survey and National Ambulatory Care Survey are set assuming comparable Prevention and Public Health Fund dollars. If funding is not comparable, the targets will need to be adjusted.

CDC also provides funding and programmatic expertise to states for the development, implementation, and adoption of electronic birth records. CDC continues a longstanding collaboration with the National Association for Public Health Statistics and Information Systems to improve the timeliness and quality of information derived from vital records and vital registration systems operated by cities, states, and territories. By the end of FY 2012, 47 of the 57 registration jurisdictions had re-engineered their birth registration systems. At the end of FY 2012, CDC funded six jurisdictions to complete the re-engineering of their birth systems and have an operational system in place by January 2014. In addition, 36 jurisdictions re-engineered death registration systems by the end of FY 2012, but a substantial number of jurisdictions had not fully implemented their systems.

***Program: Surveillance, Epidemiology, and Laboratory Services (OSELs)***

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

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012
8.B.1.3a: Increase the percentage of public health agencies that can receive production Electronic Laboratory Reporting (ELR) Meaningful Use compliant messages from certified Electronic Health Record (EHR) technology used by eligible hospitals <sup>1,2</sup> (Output)	FY 2012: 18% (Baseline)	N/A	54%	N/A
8.B.1.3b: Increase the percentage of public health agencies (or their designee) that can receive Immunization Information System (IIS) Meaningful Use compliant messages from certified Electronic Health Record (EHR) technology <sup>1,3</sup> (Output)	FY 2012: 85% (Baseline)	N/A	65%	N/A
8.B.1.3c: Increase the percentage of public health agencies that can receive production Syndromic Surveillance (SS) Meaningful Use compliant messages from certified Electronic Health Record (EHR) technology <sup>1,4</sup> (Output)	FY 2012: 2% (Baseline)	N/A	63%	N/A
8.K: Sustain the number of states developing or deploying National Electronic Disease Surveillance System (NEDSS)-compatible systems or using the NEDSS Base System, to improve case identification, investigation, and response (Output)	FY 2012: 50 (Target Met)	50	50	Maintain
8.L: Increase the average percentage of completed cell phone interviews to maintain population coverage in the Behavioral Risk Factor Surveillance System (BRFSS) (Output)	FY 2011: 14.1% (Baseline)	N/A	25%	N/A

<sup>1</sup> CDC is currently unable to track the percentage of agencies that can send EHR Meaningful Use compliant messages, but this may be possible starting in FY 2016, pending the final Meaningful Use Stage 3 criteria issued by the Office of the National Coordinator for Health Information Technology.

<sup>2</sup> ELR: The work of state public health agencies reflected in this measure is funded by the National Center for Emerging and Zoonotic Diseases through the Epidemiology and Laboratory Capacity Cooperative Agreement.

<sup>3</sup> IIS: The work of state public health agencies reflected in this measure is funded by the National Center for Immunization and Respiratory Diseases through the Section 317 program.

<sup>4</sup> SS: The work of state public health agencies reflected in this measure is funded through the Office of Public Health Preparedness and Response.

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

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012
8.B.2.1: Increase the reach of the Morbidity and Mortality Weekly Report (MMWR), as measured by the number of electronic and print subscribers (Output)	FY 2012: 164,324 (Target Exceeded)	145,648	179,737	+34,089
8.B.2.2: Increase the electronic media reach of CDC Vital Signs through the use of mechanisms such as the CDC website and social media outlets, as measured by page views, social media followers, and texting and email subscribers (Output)	FY 2012: 1,829,111 (Target Exceeded)	1,169,208	1,959,343	+790,135
8.B.2.5: Increase access to and awareness of the Guide to Community Preventive Services, and Task Force findings and recommendations, using page views as proxy for use <sup>1</sup> (Outcome)	FY 2012: 1,220,956 (Target Exceeded)	973,724	1,220,956	+247,232

<sup>1</sup>FY 2012 targets and results reflect ACA/PPHF funding.

**Performance Measures for Long Term Objective: Prepare frontline state and local health departments and laboratories to respond to current and emerging public health threats.**

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012
8.B.3.2: Increase the percentage of public health and clinical laboratory professionals who improve laboratory policies and practices as a result of participating in CDC laboratory training workshops (Outcome)	FY 2012: 58% (Baseline)	N/A	60%	N/A

**Informatics Performance Trends:** CDC developed new measures for FY 2014 to reflect the contribution of the informatics program and CDC program partners to the “Electronic Health Records – Meaningful Use” (EHR-MU) initiative. CDC is strengthening its capacity to assess and ensure readiness of three key systems in each state: Electronic Laboratory Reporting, Immunization Information Systems, and Syndromic Surveillance. Public health agencies will need to test their capability to receive data in Meaningful Use-compliant format (i.e., Health Level 7 (HL7) 2.5.1 and 2.3.1 standards) from eligible hospitals, i.e. those hospitals with certified EHRs participating in the Centers for Medicare and Medicaid Services' Meaningful Use program. In FY 2014, Meaningful Use stage two requires all Immunization Information Systems providers to use HL7 version 2.5.1 format only. While providers currently using HL7 version 2.3.1 format are likely to be grandfathered in, CDC still anticipates a drop in capability with the transition to HL7 version 2.5.1, and has set a reduced target for FY 2014 (Measure 8.B.1.3b). CDC expects significant capability gains in FY 2013 and FY 2014 for Electronic Laboratory Reporting and Syndromic Surveillance as healthcare and public health agencies strive to meet the Meaningful Use program’s stage one and two requirements identified for FY 2014 (Measures 8.B.1.3a and 8.B.1.3c). Public health agencies are not currently required to develop the ability to send messages to eligible providers and hospitals. The Office of National Coordinator for Health Information Technology is considering whether sending information to EHRs from public health agencies will be a stage three measure which would begin in FY 2016. However, it would likely only apply to Immunization Information Systems.

Surveillance Performance Trends: The National Notifiable Disease Surveillance System (NNDSS) monitors nationally reported cases of 77 diseases and funds 63 state and local jurisdictions to conduct disease detection and reporting. National data allows CDC to monitor trends, evaluate the effectiveness of prevention and control activities, conduct program planning and evaluation, develop public health policy, and conduct research. Currently, 18 states and Washington, D.C. use the CDC-developed National Electronic Disease Surveillance System (NEDSS)-Base System to transmit data to NNDSS. Another 28 states use a NEDSS-compatible system, and four states are implementing a NEDSS-compatible system. The remaining state, local, and territorial health departments provide data to CDC using other electronic and telephonic systems. As a result, jurisdictions are able to implement integrated surveillance systems to manage investigation and response activities, and enable data analyses for public health action. Jurisdictions have improved their ability to exchange data electronically with partners for surveillance purposes (Measure 8.K). For instance, Alabama found the NEDSS-Base System improved information sharing between local offices and the state health department. This facilitated faster follow-up on cases and earlier detection of cross-jurisdictional outbreaks.

CDC initially established the Behavioral Risk Factor Surveillance System (BRFSS) as a landline telephone-based health survey system conducted by states and territories. However, advances in telecommunications, most notably the development of cell phones, have impacted the ability of the BRFSS to operate as originally designed. The number of cell phone-only households has grown rapidly and data indicate that cell phone-only adults tend to have different demographics and risk behaviors than adults with a landline telephone. CDC introduced a new output measure for FY 2014 to track progress in increasing the percentage of cell phone interviews. To maintain the validity of the BRFSS, CDC increased cell phone interviews conducted from 4.5 percent in FY 2009 to 14.1 percent in FY 2011 (Measure 8.L). The 2011 BRFSS public use data set is the first to include data from both cell phone and landline respondents. Including cell phone data has affected some 2011 prevalence estimates—such as smoking and heavy drinking—that are more common among younger respondents who were under-represented in the landline-only survey.

Epidemiology Performance Trends: In FY 2012 CDC delivered critical epidemiological data and recommendations for solving public health problems to over 160,000 clinicians, epidemiologists, laboratorians, and other public health professionals through electronic and print communications published in the Morbidity and Mortality Weekly Report (MMWR). The number of MMWR subscribers has increased by approximately 115 percent since 2008, exceeding the target for four consecutive years (Measure 8.B.2.1). CDC anticipates the number of subscribers will continue to increase over the next two years. Similarly, the electronic media reach of CDC Vital Signs—a monthly program that targets the public, healthcare professionals, and policymakers through, fact sheets, social media, a website (<http://www.cdc.gov/vitalsigns>) and a linked issue of the MMWR—grew to over 1.9 million communications channels due to print, broadcast and cable media interest (Measure 8.B.2.2). CDC exceeded the FY 2011 and FY 2012 targets, but anticipates slower growth in the future, as media saturation is likely.

Community Guide findings and recommendations help decision makers, practitioners, and researchers select prevention strategies best suited to their settings and populations. In FY 2011 CDC established a performance measure to track access to and awareness of Community Guide findings and recommendations using page views of the Community Guide website (<http://www.thecommunityguide.org>) as a proxy for use (Measure 8.B.2.5). In FY 2012 CDC experienced 1,220,956 page views on the Community Guide website, exceeding the FY 2012 target by 25 percent. CDC will maintain this level of performance in FY 2014. A new measure to track use of the Community Guide's evidence-based findings and recommendations is in development. Additionally, in FY 2012, the Community Guide completed 14 systematic reviews in the following areas: tobacco use, cardiovascular disease, skin cancer, mental health, health equity, alcohol, and motor vehicle-related injury.

**Laboratory Science Performance Trends:** CDC developed a new, expanded measure for FY 2014 that tracks improvements to laboratory practices and policies resulting from CDC trainings (Measure 8.B.3.2). The new measure tracks “positive training outcomes” or improvements made in laboratory practice and policy as a result of all CDC laboratory workshops, providing more comprehensive data on outcomes of CDC laboratory workshops. Improvements include more accurate and timely test results for better community and patient health as well as safer and more secure laboratories, thereby protecting both laboratory professionals and the community at large. CDC calculates results by dividing the number of training participants who report making improvements by the total number of participants who respond to a survey conducted three to six months following training or who participate in a post-training proficiency testing challenge. CDC considers participants who successfully complete proficiency-testing challenges to have made a positive change based on their demonstrated ability to apply the skills learned in training in their own laboratory environment.

***Program: Public Health Workforce and Career Development<sup>1</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 Target	FY 2014 Target	FY 2014 +/- FY 2012
8.B.4.1: Maintain the number of all CDC trainees who join public health fellowship programs in local, state, and federal health departments to participate in training in epidemiology, preventive medicine, or public health leadership and management. <sup>2</sup> (Output)	FY 2012: 230 (Target Exceeded)	200	230	+30
8.B.4.2: Increase the number of CDC trainees in state, tribal, local, and territorial public health agencies. <sup>3</sup> (Output)	FY 2012: 335 (Target Exceeded)	237	298	+61
8.B.4.3: Increase the number of new CDC trainees who join public health fellowship programs in epidemiology, preventive medicine, public health leadership and management, informatics, or prevention effectiveness, and participate in training at federal, state, tribal, local, and territorial public health agencies. <sup>4</sup> (Output)	FY 2012: 243 (Target Exceeded)	176	212	+36

<sup>1</sup>FY 2012 targets and results for 8.B.4.1, 8.B.4.2 and 8.B.4.3 reflect some ACA/PPHF funding.

<sup>2</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>3</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), Emerging Infectious Diseases (EID) Laboratory Fellowship, CDC/CSTE Applied Epidemiology Fellowship, Health Systems Integration Program (HSIP), and Applied Public Health Informatics Fellowship (APHIF).

<sup>4</sup>8.B.4.3 includes NEW CDC-funded trainees in EIS, PHPS, PMR/F, PHIFP, PHAP, Prevention Effectiveness Fellowship (PEF), and Presidential Management Fellows (PMF) program.

**Performance Trends:** CDC’s experiential fellowship programs contribute to the public health workforce pipeline, helping to fill a critical need, as the public health workforce has decreased by at least 57,000 jobs since 2008. In 2012, 84 percent of CDC’s fellowship program graduates pursued careers in public health practice, while less than 25 percent of graduates of schools of public health did so. CDC met or exceeded its target for four of the past five years for the number of new and continuing trainees in three long-standing CDC fellowship programs: the Epidemic Intelligence Service (EIS), Public Health

Prevention Service (PHPS), and Preventive Medicine Residency/Fellowship (PMR/F) (Measure 8.B.4.1). In FY 2014 CDC will support 230 trainees in these programs, maintaining current performance. Over the past two years, CDC exceeded the targets for its other measures focused on training the next generation of the public health workforce (Measures 8.B.4.2 and 8.B.4.3). CDC sets the targets based on the typical, annual class size for each of the fellowship programs included in these measures. In FYs 2010, 2011, and 2012, CDC leveraged resources from other CDC programs and the Prevention and Public Health Fund (PPHF) to support an increase in the number of trainees. Fellowship programs tracked by Measures 8.B.4.2 and 8.B.4.3 are not proposed to receive additional PPHF funding in FY 2014, and therefore, CDC has set targets that are greater than the FY 2012 targets, but more modest than the FY 2012 results.

CDC's fellowship programs promote service while learning—fellows fill critical workforce needs at CDC and in state, tribal, local, and territorial (STLT) public health agencies while training for careers in public health. By FY 2012, CDC increased the number of trainees in STLT public health agencies from 119 trainees in 2009 to 335 (Measure 8.B.4.2) by targeting funding to fellowship programs that place fellows in STLT public health agencies. This strengthened workforce capacity in several critical disciplines, such as applied epidemiology, public health management, and informatics. As of September 30, 2012, CDC supported 546 fellows, 339 (62 percent) of whom were in state, tribal, local and territorial field assignments in 45 states, the District of Columbia, American Samoa, Puerto Rico, and five tribal locations. CDC assigned the remainder to headquarters. In FY 2012, PPHF supported 251 (74 percent) of CDC's 339 fellows in STLT public health agencies.

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

<b>DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR DISEASE CONTROL AND PREVENTION FY 2014 DISCRETIONARY STATE/FORMULA GRANTS CFDA NUMBER: 93283 BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM</b>				
STATE/TERRITORY	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
<b>Alabama</b>	\$234,352	\$234,352	\$234,352	\$0
<b>Alaska</b>	\$305,941	\$305,941	\$305,941	\$0
<b>Arizona</b>	\$267,044	\$267,044	\$267,044	\$0
<b>Arkansas</b>	\$238,182	\$238,182	\$238,182	\$0
<b>California</b>	\$303,492	\$303,492	\$303,492	\$0
<b>Colorado</b>	\$353,797	\$353,797	\$353,797	\$0
<b>Connecticut</b>	\$275,295	\$275,295	\$275,295	\$0
<b>Delaware</b>	\$166,481	\$166,481	\$166,481	\$0
<b>District of Columbia</b>	\$285,977	\$285,977	\$285,977	\$0
<b>Florida</b>	\$192,018	\$192,018	\$192,018	\$0
<b>Georgia</b>	\$201,334	\$201,334	\$201,334	\$0
<b>Hawaii</b>	\$269,849	\$269,849	\$269,849	\$0
<b>Idaho</b>	\$247,486	\$247,486	\$247,486	\$0
<b>Illinois</b>	\$235,567	\$235,567	\$235,567	\$0
<b>Indiana</b>	\$212,414	\$212,414	\$212,414	\$0
<b>Iowa</b>	\$241,797	\$241,797	\$241,797	\$0
<b>Kansas</b>	\$458,586	\$458,586	\$458,586	\$0
<b>Kentucky</b>	\$202,186	\$202,186	\$202,186	\$0
<b>Louisiana</b>	\$238,182	\$238,182	\$238,182	\$0
<b>Maine</b>	\$240,456	\$240,456	\$240,456	\$0

<b>DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR DISEASE CONTROL AND PREVENTION FY 2014 DISCRETIONARY STATE/FORMULA GRANTS CFDA NUMBER: 93283 BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM</b>				
STATE/TERRITORY	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Maryland	\$282,377	\$282,377	\$282,377	\$0
Massachusetts	\$294,372	\$294,372	\$294,372	\$0
Michigan	\$318,839	\$318,839	\$318,839	\$0
Minnesota	\$259,564	\$259,564	\$259,564	\$0
Mississippi	\$220,776	\$220,776	\$220,776	\$0
Missouri	\$224,592	\$224,592	\$224,592	\$0
Montana	\$307,527	\$307,527	\$307,527	\$0
Nebraska	\$225,437	\$225,437	\$225,437	\$0
Nevada	\$273,818	\$273,818	\$273,818	\$0
New Hampshire	\$296,221	\$296,221	\$296,221	\$0
New Jersey	\$309,314	\$309,314	\$309,314	\$0
New Mexico	\$274,316	\$274,316	\$274,316	\$0
New York	\$306,258	\$306,258	\$306,258	\$0
North Carolina	\$350,422	\$350,422	\$350,422	\$0
North Dakota	\$212,281	\$212,281	\$212,281	\$0
Ohio	\$207,637	\$207,637	\$207,637	\$0
Oklahoma	\$221,855	\$221,855	\$221,855	\$0
Oregon	\$320,444	\$320,444	\$320,444	\$0
Pennsylvania	\$199,648	\$199,648	\$199,648	\$0
Rhode Island	\$214,006	\$214,006	\$214,006	\$0
South Carolina	\$295,111	\$295,111	\$295,111	\$0
South Dakota	\$170,951	\$170,951	\$170,951	\$0
Tennessee	\$165,783	\$165,783	\$165,783	\$0
Texas	\$252,566	\$252,566	\$252,566	\$0
Utah	\$322,040	\$322,040	\$322,040	\$0
Vermont	\$170,964	\$170,964	\$170,964	\$0
Virginia	\$189,660	\$189,660	\$189,660	\$0
Washington	\$326,535	\$326,535	\$326,535	\$0
West Virginia	\$282,377	\$282,377	\$282,377	\$0
Wisconsin	\$286,800	\$286,800	\$286,800	\$0
Wyoming	\$290,785	\$290,785	\$290,785	\$0
<b>State Sub-Total</b>	<b>\$13,243,712</b>	<b>\$13,243,712</b>	<b>\$13,243,712</b>	<b>\$0</b>
America Samoa	\$77,190	\$77,190	\$77,190	\$0
Guam	\$146,792	\$146,792	\$146,792	\$0
Micronesia	\$48,466	\$48,466	\$48,466	\$0
Puerto Rico	\$190,913	\$190,913	\$190,913	\$0
Palau	\$127,192	\$127,192	\$127,192	\$0
Virgin Islands	\$234,198	\$234,198	\$234,198	\$0

<b>DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR DISEASE CONTROL AND PREVENTION FY 2014 DISCRETIONARY STATE/FORMULA GRANTS CFDA NUMBER: 93283 BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM</b>				
STATE/TERRITORY	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
<b>Territory Sub-Total</b>	<b>\$824,751</b>	<b>\$824,751</b>	<b>\$824,751</b>	<b>\$0</b>
<b>Total States/Territories</b>	<b>\$14,068,463</b>	<b>\$14,068,463</b>	<b>\$14,068,463</b>	<b>\$0</b>

<sup>1</sup> Table does not include non-core BRFSS funding from other CDC programs and the Affordable Care Act/Prevention and Public Health Fund.

<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/>.

<b>DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR DISEASE CONTROL AND PREVENTION FY 2014 DISCRETIONARY STATE/FORMULA GRANTS CFDA NUMBER: 93283 NATIONAL NOTIFIABLE DISEASES SURVEILLANCE SYSTEM (NNDSS)</b>				
STATE/TERRITORY	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Alabama	\$240,108	\$240,108	\$240,108	\$0
Alaska	\$224,698	\$224,698	\$224,698	\$0
American Samoa	\$57,801	\$57,801	\$57,801	\$0
Arizona	\$99,973	\$99,973	\$99,973	\$0
Arkansas	\$109,699	\$109,699	\$109,699	\$0
California	\$300,191	\$300,191	\$300,191	\$0
Chicago	\$136,789	\$136,789	\$136,789	\$0
Colorado	\$232,876	\$232,876	\$232,876	\$0
Commonwealth of Puerto Rico	\$80,214	\$80,214	\$80,214	\$0
Commonwealth of Northern Mariana Islands	\$24,210	\$24,210	\$24,210	\$0
Connecticut	\$180,491	\$180,491	\$180,491	\$0
Delaware	\$77,496	\$77,496	\$77,496	\$0
Federated States of Micronesia	\$9,580	\$9,580	\$9,580	\$0
Florida	\$128,120	\$128,120	\$128,120	\$0
Georgia	\$124,080	\$124,080	\$124,080	\$0
Guam	\$172,978	\$108,488	\$108,488	-\$64,490
Hawaii	\$181,493	\$181,493	\$181,493	\$0
Houston	\$146,533	\$146,533	\$146,533	\$0
Idaho	\$108,118	\$108,118	\$108,118	\$0
Illinois	\$141,188	\$141,188	\$141,188	\$0
Indiana	\$97,366	\$97,366	\$97,366	\$0
Iowa	\$202,571	\$202,571	\$202,571	\$0
Kansas	\$159,205	\$159,205	\$159,205	\$0
Kentucky	\$71,521	\$71,521	\$71,521	\$0
Los Angeles	\$280,649	\$280,649	\$280,649	\$0

<b>DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR DISEASE CONTROL AND PREVENTION FY 2014 DISCRETIONARY STATE/FORMULA GRANTS CFDA NUMBER: 93283 NATIONAL NOTIFIABLE DISEASES SURVEILLANCE SYSTEM (NNDSS)</b>				
STATE/TERRITORY	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Louisiana	\$257,449	\$257,449	\$257,449	\$0
Maine	\$125,200	\$125,200	\$125,200	\$0
Maryland	\$323,770	\$323,770	\$323,770	\$0
Massachusetts	\$149,344	\$149,344	\$149,344	\$0
Michigan	\$94,580	\$94,580	\$94,580	\$0
Minnesota	\$264,192	\$264,192	\$264,192	\$0
Mississippi	\$86,954	\$86,954	\$86,954	\$0
Missouri	\$182,327	\$182,327	\$182,327	\$0
Montana	\$136,460	\$136,460	\$136,460	\$0
Nebraska	\$235,433	\$235,433	\$235,433	\$0
Nevada	\$198,903	\$198,903	\$198,903	\$0
New Hampshire	\$142,655	\$142,655	\$142,655	\$0
New Jersey	\$199,650	\$199,650	\$199,650	\$0
New Mexico	\$111,944	\$111,944	\$111,944	\$0
New York	\$373,484	\$373,484	\$373,484	\$0
New York City	\$210,574	\$210,574	\$210,574	\$0
North Carolina	\$98,407	\$98,407	\$98,407	\$0
North Dakota	\$108,574	\$108,574	\$108,574	\$0
Ohio	\$332,561	\$332,561	\$332,561	\$0
Oklahoma	\$135,941	\$135,941	\$135,941	\$0
Oregon	\$252,640	\$252,640	\$252,640	\$0
Pennsylvania	\$263,963	\$263,963	\$263,963	\$0
Philadelphia	\$92,037	\$92,037	\$92,037	\$0
Republic of Marshall Islands	\$24,610	\$24,610	\$24,610	\$0
Republic of Palau	\$45,508	\$45,508	\$45,508	\$0
Rhode Island	\$216,631	\$216,631	\$216,631	\$0
South Carolina	\$159,325	\$159,325	\$159,325	\$0
South Dakota	\$58,827	\$58,827	\$58,827	\$0
Tennessee	\$164,572	\$164,572	\$164,572	\$0
Texas	\$74,256	\$74,256	\$74,256	\$0
Utah	\$124,969	\$124,969	\$124,969	\$0
Vermont	\$205,040	\$205,040	\$205,040	\$0
Virginia	\$350,727	\$350,727	\$350,727	\$0
Virgin Islands	\$0	\$79,880	\$79,880	\$79,880
Washington	\$264,765	\$264,765	\$264,765	\$0
Washington, District of Columbia	\$151,644	\$151,644	\$151,644	\$0
West Virginia	\$182,844	\$182,844	\$182,844	\$0
Wisconsin	\$184,210	\$184,210	\$184,210	\$0

<b>DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR DISEASE CONTROL AND PREVENTION FY 2014 DISCRETIONARY STATE/FORMULA GRANTS CFDA NUMBER: 93283 NATIONAL NOTIFIABLE DISEASES SURVEILLANCE SYSTEM (NNDSS)</b>				
STATE/TERRITORY	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Wyoming	\$171,035	\$171,035	\$171,035	\$0
<b>Total States/Territories</b>	<b>\$10,343,953</b>	<b>\$10,359,343</b>	<b>\$10,359,343</b>	<b>\$15,390</b>