

Part III.
Performance Plan Appendices

Appendix A Linkage to HHS Strategic Plan

CDC has adopted key parts of the DHHS strategic plan, which was recently revised, to move the agency forward into the 21st century. The DHHS strategic plan has eight broad goals that are supported by multiple objectives. CDC's programs support multiple goals and objectives of the plan. A crosswalk delineating the relationship between CDC's programs and the DHHS Strategic Plan is located at Appendix A.1.

DHHS' strategic goals set the stage for actions that, on a daily basis, improve the quality of people's lives throughout the world. When it comes to action, CDC focuses its expertise and other resources in three principal areas:

Protecting the health and safety of Americans – CDC addresses DHHS Goals 1 and 4 through actions generated from science-based programs. Serious threats to the nation's health come from many sources: diseases, organisms, injuries, behaviors, emerging risks. Meeting these complex health problems head-on requires CDC to be both nimble and flexible – that is, to adapt resources and balance priorities as needed, to use diverse tactics, and to forge effective partnerships.

Dramatic gains in life expectancy have resulted largely from improvements in sanitation and the prevention of diseases through vaccines. A century ago, pneumonia and TB were the two leading causes of death in the United States. Then, in the 1940s, a critical focus of the nation's health priorities was the control of malaria among military personnel during World War II. From these programs came the genesis of the Centers for Disease Control and Prevention, and since that time CDC has been at the forefront of the nation's efforts to improve the health and well-being of Americans.

As we move into a new century, many of CDC's resources are dedicated to solving complex, cross-cutting health problems that require a broad array of skills, abilities, and experience. For example, since the 1960s and 1970s, community-based programs have helped to produce more recent reductions in tobacco use, increases in blood pressure control, healthier diets, increased use of seat belts, and effective injury control. These improvements and others have contributed in turn to declines in deaths from stroke and heart disease and declines in overall death rates for children. Yet, despite these successes, heart disease and cancer have remained the leading causes of death through the latter part of the 20th century.

Today, CDC and partners confront challenging, complex issues that reinforce, reshape, and expand the traditional roles of public health. Responding to those challenges involves such activities as:

- Investigating disease outbreaks in the United States and around the world;
- Probing the realms of viruses, bacteria, and parasites to uncover ways to control both emerging and re-emerging pathogens;
- Protecting the food and water supplies from both inadvertent and deliberate contamination;
- Curbing the toll of death and disability from preventable injuries;
- Stemming the epidemic of obesity in the United States;
- Convincing the public that altering certain behaviors will yield long-term health dividends;
- Educating youth about the risks of HIV, unintended pregnancy, tobacco use, physical inactivity, and poor nutrition;

Appendix A Linkage to HHS Strategic Plan

- Translating biomedical research findings into practice in communities; and
- Eliminating disparities in the health of all Americans.

Protecting health and safety has its basis in science. CDC staff use the applied techniques of epidemiology, laboratory, behavioral, and social sciences as the primary tools to understand the causes of poor health, identify populations at risk, and develop interventions for disease control and prevention. As research provides more information about the relationships among the physical, mental, and social dimensions of well-being, a broader approach to public health has become important in the quest for answers to prevent and solve health problems. CDC is committed to expanding its research agenda to help bridge the gap between research and protecting health and safety.

Providing credible information to enhance health decisions – CDC addresses DHHS Goal 5 by providing credible, timely health information to help policy makers, providers, and consumers make informed decisions about personal and public health. The general public and health practitioners at all levels require up-to-date, credible information about health and safety to make rational decisions. To help support this crucial decision making, CDC continues to increase and apply its preeminent expertise in the disciplines of public health surveillance, epidemiology, statistical analysis, laboratory investigation and analysis, health communications and social marketing, behavioral risk reduction, technology transfer, and prevention research. CDC applies the science that underpins those disciplines to develop and disseminate credible and practical health information to meet the diverse needs of its primary clients, the people of the United States. Such information affects health and well-being across all stages of life when the best possible health decisions must be made by consumers, providers, and policy makers.

CDC makes this crucial health information available through many channels, including books, periodicals, and monographs; Internet websites; health and safety guidelines; reports from investigations and emergency responses; public health monitoring and statistics; travel advisories; and answers to public inquiries.

In addition to serving the public, CDC delivers health information that enables providers to make critical decisions. For example, the practicing medical and dental communities and the nation's healthcare providers are target audiences for numerous official CDC recommendations on the diagnosis and treatment of disease, immunization schedules, infection control, and clinical prevention practices. CDC also offers technical assistance and training to health professionals.

CDC is positioned in vanguard efforts to inform people about the benefits of having children wear bicycle helmets, teaching young women about preventing birth defects by taking folic acid, quitting smoking, eating sensibly and exercising regularly, reducing health hazards during food preparation in the home, making sure children and adults are vaccinated, and alerting the public to environmental hazards. CDC recognizes that many other public health messages either need to be heard for the first time or should be reinforced.

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Promoting health through strong partnerships – CDC addresses DHHS Goal 2 through strong working relationships with key public health partners. CDC has a long history of developing and sustaining vital partnerships with various public and private entities that improve service to the American people. CDC's partners in conducting effective prevention and control activities include:

- Public health associations;
- State and local public health agencies;
- Other DHHS agencies and agencies in other federal departments;
- Practicing health professionals, including physicians, dentists, nurses, and veterinarians;
- Public safety and security officials;
- Schools and universities;
- Communities of faith;
- Community, professional, and philanthropic organizations;
- Nonprofit and voluntary organizations;
- Business, labor, and industry;
- CDC Foundation and other foundations;
- International health organizations; and
- State and local departments of education.

CDC's partners implement most of the agency's extramural programs. These programs are tailored to reflect local and community needs. In addition, partners strengthen CDC by serving as consultants to CDC program staff, by participating in CDC advisory committees, and by attending CDC-sponsored seminars and conferences. The wide-ranging perspectives that CDC's partners bring to common interests and goals generate new opportunities for collaborations, help shape key strategies, and provide another means for staying focused on the needs of the American public. Sustaining these partnerships involves coordination and communication.

Appendix A.1

CDC Budget Activities and Related HHS Strategic Goals

CDC budget activities which correspond to goals outlined in the HHS Strategic Plan are indicated by a check mark. As a whole, CDC is working towards Goal 8, achieving excellence in management practices. The remaining seven goals and their specific objectives are listed for programs where appropriate; detailed goals and objectives are provided following the table.

Budget Activity/ HHS Goal	Goal 1 Reduce major threats to health	Goal 2 Enhance public health response	Goal 3 Increase access to care	Goal 4 Enhance health sciences research	Goal 5 Improve quality of health care	Goal 6 Improve economic and social well-being	Goal 7 Improve stability, development of youth	HHS Objectives
Birth Defects/Dev. Disabilities & Health			✓	✓	✓	✓	✓	3.4, 3.5, 4.1, 4.4, 5.2, 6.3, 7.2
Chronic Disease Prevention and Health Promotion	✓		✓	✓	✓	✓		1.1, 1.2, 1.5, 2.1, 3.4, 3.5, 3.6, 4.1, 4.3, 4.4, 5.2, 6.2, 6.5
Environmental Health	✓	✓	✓	✓			✓	1.1, 2.1, 3.4, 4.1, 4.4, 5.1, 5.5, 7.2, 7.4
Epidemic Services & Response		✓		✓	✓			1.1, 1.2, 1.5, 1.6, 2.1, 2.2, 4.1, 4.3, 4.4, 5.3, 5.4, 5.5
Health Statistics				✓	✓			1.1, 1.2, 1.3, 1.5, 1.6, 2.1, 3.1, 3.2, 3.4, 3.5, 4.1, 4.4, 4.5, 5.1, 5.2, 5.3, 5.5, 6.2, 6.3, 7.1, 7.2, 7.4
HIV, STD, & TB Prevention	✓		✓	✓	✓	✓		1.1, 1.2, 2.1, 3.4, 3.5, 3.6, 4.1, 4.4, 5.2, 5.3, 5.4, 6.3
Immunization	✓		✓	✓	✓			1.3, 2.1, 2.2, 3.4, 3.5, 3.6, 4.1, 4.3, 4.4, 4.5, 5.5, 5.2, 5.3, 6.2, 6.3, 6.5, 7.2, 7.4,
Infectious Diseases Control		✓		✓	✓			2.1, 2.2, 4.1, 4.4, 5.1, 5.2, 5.3
Injury Prevention and Control	✓	✓	✓	✓	✓	✓		1.6, 2.2, 3.4, 3.6, 4.1, 4.4, 5.2, 5.3, 6.2, 6.3
Occupational Safety and Health	✓		✓	✓	✓			1.6, 3.5, 4.1, 4.3, 4.4, 4.5, 5.3, 5.4
Preventive Health and Health Services Block Grant	✓	✓	✓		✓	✓	✓	1.1, 1.2, 1.3, 1.4, 1.5, 1.6, 2.1, 2.2, 3.4, 3.5, 3.6, 5.2, 5.5, 6.2, 6.3, 6.5, 7.2
Public Health Improvement		✓		✓	✓			1.1, 1.3, 2.1, 3.4, 3.5, 3.6, 4.3, 4.4, 5.2, 5.3, 5.5, 6.2, 6.5
Buildings and Facilities		✓						2.1
Office of the Director		✓		✓	✓			2.1, 4.1, 4.3, 4.4, 4.5, 5.5, 8.1, 8.2, 8.4, 8.5, 8.6, 8.7
Terrorism								2.1, 2.2, 4.1, 4.2, 4.4, 5.5

Appendix A.1
HHS Strategic Plan Goals

1. Reduce the major threats to the health and well-being of Americans

- 1.1 Reduce risky behaviors and other factors that contribute to the development of chronic diseases, especially diabetes and asthma
- 1.2 Reduce the proportion of adolescents engaged in sexual activity, the proportion of persons engaged in unsafe sexual behaviors, and unintended pregnancies
- 1.3 Increase immunization rates among adults and children
- 1.4 Reduce substance abuse by expanding and improving communities' substance abuse prevention and treatment programs.
- 1.5 Reduce tobacco use, especially among youth
- 1.6 Reduce the incidence and consequences of injuries and violence

2. Enhance the ability of the Nation's public health system to effectively respond to bioterrorism and other public health challenges

- 2.1 Build the capacity of the health care system to respond to public health threats in a more timely and effective manner, especially bioterrorism threats
- 2.2 Improve the safety of food, drugs, biological products, and medical devices

3. Increase the percentage of the Nation's children and adults who have access to regular health care and expand consumer choices

- 3.1 Create new, affordable health insurance options
- 3.2 Expand the health care safety net
- 3.3 Strengthen and improve Medicare
- 3.4 Eliminate racial and ethnic health disparities
- 3.5 Expand access to health care services for populations with special needs
- 3.6 Increase access to health care services for American Indians and Alaska Native (AI/AN)

4. Enhance the capacity and productivity of the Nations health science research enterprise

- 4.1 Advance the understanding of basic biomedical and behavioral science and how to prevent, diagnose, and treat disease and disability
- 4.2 Accelerate private sector development of new drugs, biologic therapies, and medical technology
- 4.3 Strengthen and diversify the base of qualified health and behavioral science researchers
- 4.4 Improve the coordination, communication, and application of health research results
- 4.5 Strengthen the mechanisms for ensuring the protection of human subjects and the integrity of the research process

Appendix A.1
HHS Strategic Plan Goals

5. Improve the quality of health care services

- 5.1 Reduce medical errors
- 5.2 Increase the appropriate use of effective health care services
- 5.3 Increase consumer and patient use of health care quality information
- 5.4 Improve consumer and patient protections
- 5.5 Accelerate the development and use of an electronic health information infrastructure

6. Improve the economic and social well-being of individuals, families, and communities, especially those most in need

- 6.1 Increase the economic independence and workforce participation of low income families and persons receiving welfare
- 6.2 Increase the proportion of older Americans who stay active and healthy
- 6.3 Increase the independence and quality of life of persons with long-term care needs
- 6.4 Improve the economic and social development of distressed communities
- 6.5 Expand community and faith-based partnerships

7. Improve the stability and development of our Nation's children and youth

- 7.1 Promote family formation and healthy marriages
- 7.2 Improve the development and learning readiness of preschool children
- 7.3 Increase the involvement and financial support of non-custodial parents in the lives of their children
- 7.4 Increase the percentage of children and youth living in a permanent, safe environment

8. Achieve excellence in management practices

- 8.1 Create a unified HHS committed to functioning as One Department
- 8.2 Improve the strategic management of human capital
- 8.3 Enhance the efficiency and effectiveness of competition between public and private service providers
- 8.4 Improve financial management
- 8.5 Enhance the use of electronic commerce in service delivery and record keeping
- 8.6 Achieve integration of budget and performance information
- 8.7 Reduce regulatory burden on providers and consumers of HHS services

**Review of FY 2004 HHS Performance Plans
Areas of Consistency between CDC and Other Plans**

At the request of the Department, CDC reviewed the goals and performance measures of each OPDIV and StaffDiv to ascertain whether there were inconsistencies among the measures and targets. No inconsistencies were found. However, some similar goals and measures were identified during this process. This appendix documents those areas.

Similar Measures in Other OPDIV Plans	CDC Measures/Targets	Comments
CMS		
Increase annual influenza (flu) and lifetime pneumococcal vaccinations (MCBS)	Increase the rate of influenza and pneumococcal pneumonia vaccination in persons ≥ 65 years.	Goals are complementary. CDC and CMS have collaborated on this activity for several years. Collaborative efforts include conference calls at the policy and programmatic levels of each organization, as well as mutual data sharing and mutual target setting.
– Flu FY 04: 72.5% FY 03: 72.5% FY 02: 72% FY 01: 72% FY 00: NA	FY 04: Influenza 72.5% Pneumococcal 69% FY 03: Influenza 76% Pneumococcal 69% FY 02: Influenza 74% Pneumococcal 66% FY 01: Influenza: *72% Pneumococcal 63% FY 00: Influenza 70% Pneumococcal 60% FY 99: Influenza 60% Pneumococcal 54%	
– Pneumococcal FY 04: 69% FY 03: 69% FY 02: 66% FY 01: 63% FY 00: NA		

Appendix A.2

Similar Measures in Other OPDIV Plans	CDC Measures/Targets	Comments
CMS (continued)		
<p>Increase the Percentage of Medicaid Two-Year Old Children Who are Fully Immunized (Developmental)</p> <p>-- Group I</p> <p>FY 04: 3-year reporting period complete FY 03: Measure State-specific immunization rate- Achieve State target FY 02: Measure State-specific immunization rates FY 01: Measure State-specific immunization rates FY 00: Complete development of State-specific methodologies and baselines</p> <p>-- Group II</p> <p>FY 04: Measure State-specific immunization rate FY 03: Measure State-specific immunization rate FY 02: Measure State-specific immunization rate FY 01: Establish State-specific baselines and targets FY 00: Identify; begin developing State-specific methodologies and baselines</p> <p>- Group III</p> <p>FY 04: Measure State-specific immunization rate. FY 03: Measure State-specific immunization rate. FY 02: Establish State-specific baselines and targets FY 01: Identify; begin developing State-specific methodologies and baselines FY 00: N/A</p>	<p>Achieve or sustain immunization coverage of at least 90% in children 19- to 35-months of age for:</p> <p>3 doses DTaP vaccine 3 doses Hib vaccine 1 dose MMR vaccine* 3 doses hepatitis B vaccine 3 doses polio vaccine 1 dose varicella vaccine** 4 doses pneumococcal conjugate vaccine**</p> <p>* Includes any measles- containing vaccine. **Performance targets for newly recommended vaccines will begin 5 years after ACIP recommendation. Measures for varicella will begin in 2001and for pneumococcal conjugate measure in 2006, even though coverage will be reported earlier.</p> <p>FY 04: 90% coverage FY 03: 90% coverage FY 02: 90% coverage FY 01: 90% coverage FY 00: 90% coverage</p>	<p>Complementary goals. CMS partners with states and collaborates with CDC to ensure that “at risk” children are immunized, thereby contributing to CDC’s over-all goal of increasing immunization rates among children 19- to 35-months of age.</p>

Appendix A.2

Similar Measures in Other OPDIV Plans	CDC Measures/Targets	Comments
CMS (continued)		
<p>Increase biennial mammography rates (NHIS)</p> <p>FY 01: Switched to new data source (see below) FY 00: 60% FY 99: 59%</p> <p>Increase biennial mammography rates (National Claims History File)</p> <p>FY 04: TBD FY 03: 53% FY 02: 52% FY 01: 51% FY 00: NA</p>	<p>Increase the number of women screened</p> <p>Breast: Mammogram or CBE</p> <p>FY 04: 255,000 breast</p>	<p>Complementary activities. CDC's NBCCEDP target population is low-income women who are uninsured or under-insured. CDC works closely with CMS to ensure that women are appropriately screened and treated. Although the NBCCEDP does not provide funding for treatment services, the Breast and Cervical Cancer Prevention and Treatment Act of 2000 ensures Medicaid services for women screened through the NBCCEDP if they are a U.S. citizen or qualified alien.</p>
<p>Improve the rate of biennial diabetic eye exams</p> <p>FY 04: TBD FY 03: 68.9% FY 02: 68.6% FY 01: 68.3% (69% recalculated)</p>	<p>For states receiving comprehensive CDC funding for diabetes control programs (DCPs), increase the percentage of persons with diabetes who receive annual eye and foot exams.</p> <p>FY04: Eye/72%; foot/62% (Increase baseline by 10%)</p> <p>FY 03: Eye/72%; foot/62% (Increase baseline by 10%)</p> <p>FY 02: Eye/72%; foot/62% (Increase baseline by 10%)</p> <p>FY 01: Eye/72%; foot/62% (Increase baseline by 10%)</p> <p>FY 00: Eye/72%; foot/62% (Increase baseline by 10%)</p>	<p>Goals are complementary. CMS' population includes Medicare eligible individuals, whereas CDC's population is limited to those states funded for comprehensive Diabetes Control Programs. CMS' data source is the National Claims History File; CDC's data source for this measure is the BRFSS. Also, CMS' goal is biennial, whereas CDC's goal is annual.</p>

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Similar Measures in Other OPDIV Plans	CDC Measures/Targets	Comments										
HRSA												
<p>Increase percent of users with diabetes who have had an annual dilated eye exam.</p> <table border="0"> <tr> <td>HP</td> <td>BPHC</td> </tr> <tr> <td>2010: 70%</td> <td>FY 04: 90%</td> </tr> <tr> <td></td> <td>FY 03: 90%</td> </tr> <tr> <td>2000: 70%</td> <td>FY 02: 90%</td> </tr> <tr> <td></td> <td>FY 01: 90%</td> </tr> </table>	HP	BPHC	2010: 70%	FY 04: 90%		FY 03: 90%	2000: 70%	FY 02: 90%		FY 01: 90%	<p>For states receiving comprehensive CDC funding for diabetes control programs (DCPs), increase the percentage of persons with diabetes who receive annual eye and foot exams.</p> <p>FY 03: Eye/72%; foot/62% (Increase baseline by 10%)</p> <p>FY 02: Eye/72%; foot/62% (Increase baseline by 10%)</p> <p>FY 01: Eye/72%; foot/62% (Increase baseline by 10%)</p> <p>FY 00: Eye/72%; foot/62% (Increase baseline by 10%)</p>	<p>Goals are complementary. HRSA's population includes individuals treated through its Community Health Centers, whereas CDC's population is limited to those states funded for comprehensive Diabetes Control Programs.</p>
HP	BPHC											
2010: 70%	FY 04: 90%											
	FY 03: 90%											
2000: 70%	FY 02: 90%											
	FY 01: 90%											

Appendix A.2

Similar Measures in Other OPDIV Plans	CDC Measures/Targets	Comments																												
HRSA (continued)																														
<p>Increase percent of health center women receiving age-appropriate screening for cervical and breast cancer.</p> <p>A) Up-to-date PAP tests</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">HP</td> <td style="width: 50%;">BPHC</td> </tr> <tr> <td>2010: 90%</td> <td>FY 04: 96%</td> </tr> <tr> <td></td> <td>FY 03: 96%</td> </tr> <tr> <td>2000: 70%</td> <td>FY 02: 95%</td> </tr> <tr> <td></td> <td>FY 01: 94%</td> </tr> <tr> <td></td> <td>FY 00: 92%</td> </tr> <tr> <td></td> <td>FY 99: 90%</td> </tr> </table> <p>B) Up-to-date mammograms</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">HP</td> <td style="width: 50%;">BPHC</td> </tr> <tr> <td>2010: 70%</td> <td>FY 04: 79%</td> </tr> <tr> <td></td> <td>FY 03: 78%</td> </tr> <tr> <td>2000: 60%</td> <td>FY 02: 75%</td> </tr> <tr> <td></td> <td>FY 01: 70%</td> </tr> <tr> <td></td> <td>FY 00: 67.5%</td> </tr> <tr> <td></td> <td>FY 99: 65%</td> </tr> </table> <p>C) Up-to-date clinical breast exams</p> <p>FY 04: 88%</p> <p>FY 03: 87%</p> <p>FY 02: 86%</p> <p>FY 01: 85.5%</p> <p>FY 00: 84%</p> <p>FY 99: 82.5%</p>	HP	BPHC	2010: 90%	FY 04: 96%		FY 03: 96%	2000: 70%	FY 02: 95%		FY 01: 94%		FY 00: 92%		FY 99: 90%	HP	BPHC	2010: 70%	FY 04: 79%		FY 03: 78%	2000: 60%	FY 02: 75%		FY 01: 70%		FY 00: 67.5%		FY 99: 65%	<p>Increase the number of women screened</p> <p>Breast: mammogram or CBE Cervical: Pap Smear</p> <p>FY 04: 255,000 breast/ 275,000 cervical</p> <p>Increase the percentage of newly enrolled women who have not received a Pap test within the past five years</p> <p>FY 04: 22.5% cervical</p>	<p>Complementary goals. HRSA population served is in Community Health Centers, whereas CDC's target population is low- income women who are uninsured or under-insured. Services are carried out in states funded as part of the NBCCEDP.</p>
HP	BPHC																													
2010: 90%	FY 04: 96%																													
	FY 03: 96%																													
2000: 70%	FY 02: 95%																													
	FY 01: 94%																													
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2000: 60%	FY 02: 75%																													
	FY 01: 70%																													
	FY 00: 67.5%																													
	FY 99: 65%																													
<p>With CDC, decrease by 5% annually the number of newly reported AIDS cases in children as a result of perinatal transmission.</p> <p>FY 04: 144 children</p> <p>FY 03: 152 children</p> <p>FY 02: 160 children</p> <p>FY 01: 151 children</p> <p>FY 00: 161 children</p> <p>FY 99: 214 children</p>	<p>Decrease the number of perinatally acquired AIDS cases, from the 1998 base of 235 cases.</p> <p>FY 04: 139 cases</p> <p>FY 03: 139 cases</p> <p>FY 02: 141 cases</p> <p>FY 01: 151 cases</p> <p>FY 00: 203 cases</p> <p>FY 99: 214 cases</p>	<p>Complementary goals. Populations served vary – HRSA's population is in Community Health Centers, whereas CDC's work is carried out in funded state and local health departments and CBOs.</p>																												

Appendix A.2

Similar Measures in Other OPDIV Plans	CDC Measures/Targets	Comments
HRSA (continued)		
<p>Provide grants to target communities to significantly reduce the number of new cases of asthma, diabetes, and obesity, and increase the number of adults and children at a healthy weight. (Developmental - more detailed measures to be established in conjunction with the working group established as goal 1 above.)</p>	<p>Reduce hospitalizations due to asthma for states that have implemented a comprehensive asthma control program.</p> <p>FY 04: 10% reduction FY 02: baseline</p> <p>Increase the number of DCPs that promote health system approaches to identifying persons who are at high risk for developing diabetes (e.g. obese and / or impaired glucose metabolism).</p> <p>FY 04: 5</p> <p>By 2010, decrease by 20% the number of people with pre-diabetes who advance to diabetes among states with pre-diabetes programs.</p> <p>FY 04: Establish baseline</p> <p>Increase the number of state or community policies and environmental supports that are initiated, modified, or planned for the primary prevention of obesity and chronic disease in funded states.</p> <p>FY 04: 12 policies, environmental supports</p> <p>Increase the number of pilot interventions for nutrition and physical activity that are scientifically tested in funded states.</p> <p>FY 04: 12 interventions</p>	<p>Complementary goals and activities. CDC and HRSA have worked closely on activities and performance measures as part of the 04 Prevention Initiative.</p>

Appendix A.2

Similar Measures in Other OPDIV Plans	CDC Measures/Targets	Comments
IHS		
<p>Increase the proportion of women who receive Pap screening.</p> <p><u>Pap Screening</u> FY 04: maintain FY 03 level FY 03: maintain FY 02 level FY 02: +2% over FY 01 level FY 01: +3% over FY 00 level FY 00: +3% over FY 99 level</p> <p><u>Cervical Cancer</u> FY 99: determine incidence of cervical cancer</p>	<p>Increase the number of women screened</p> <p>Breast: mammogram or CBE Cervical: Pap Smear</p> <p>FY 04: 255,000 breast/ 275,000 cervical</p> <p>Increase the percentage of newly enrolled women who have not received a Pap test within the past five years</p> <p>FY 04: 22.5% cervical</p>	<p>Complementary goals, with screening occurring in different clinic sites/practice settings.</p>
<p>Increase proportion of the AI/AN female population over 40 years of age who receive screening mammography.</p> <p>FY 04: maintain FY 03 level FY 03: maintain FY 02 level FY 02: +2% over FY 01 level FY 01: +2% over FY 00 level FY 00: +3% over FY 99 baseline</p> <p>FY 99: establish baseline</p>	<p>Increase the number of women screened</p> <p>Breast: mammogram or CBE Cervical: Pap Smear</p> <p>FY 04: 255,000 breast/ 275,000 cervical</p>	<p>Complementary goals, with screening occurring in different clinic sites/practice settings.</p>

Appendix A.2

Similar Measures in Other OPDIV Plans	CDC Measures/Targets	Comments
IHS (continued)		
<p>Increase the proportion of AI/AN children who have completed all recommended immunizations by the age two.</p> <p>FY 04: FY 03: at FY 02 level FY 02: +1% over FY 01 level FY 01: +1% over FY 00 level FY 00: +2% over FY 99 level FY 99: 91%</p>	<p>Achieve or sustain immunization coverage of at least 90% in children 19- to 35-months of age for:</p> <p>3 doses DTaP vaccine 3 doses Hib vaccine 1 dose MMR vaccine* 3 doses hepatitis B vaccine 3 doses polio vaccine 3 doses varicella vaccine** 4 doses pneumococcal conjugate vaccine**</p> <p>* Includes any measles- containing vaccine. **Performance targets for newly recommended vaccines will begin 5 years after ACIP recommendation. Measures for varicella will begin in 2001and for pneumococcal conjugate measure in 2006, even though coverage will be reported earlier.</p> <p>FY 04: 90% coverage FY 03: 90% coverage FY 02: 90% coverage FY 01: 90% coverage FY 00: 90% coverage</p>	<p>Complementary goals, with IHS measure supporting CDC's over-all goal of increasing immunization rates among 2-year-olds.</p>
<p>Increase overall pneumococcal vaccination levels among AI/AN diabetics and elderly.</p> <p>FY 04: FY 03: no indicator FY 02: no indicator FY 01: secure electronic baseline FY 00: 65%</p>	<p>Increase the rate of influenza and pneumococcal pneumonia vaccination in persons ≥65 years.</p> <p>FY 04: Influenza 76% Pneumococcal 69% FY 03: Influenza 76% Pneumococcal 69% FY 02: Influenza 74% Pneumococcal 66% FY 01: Influenza: *72% Pneumococcal 63% FY 00: Influenza 70% Pneumococcal 60% FY 99: Influenza 60% Pneumococcal 54%</p>	<p>Complementary goal with IHS' measure supporting CDC's over-all measure of increasing vaccination levels among those ≥65.</p>

Appendix A.2

Similar Measures in Other OPDIV Plans	CDC Measures/Targets	Comments
NIH		
<p>NIH Communication of Results</p> <p><u>Goal c</u> - Increase awareness of NIH-sponsored research results among the general public.</p> <p><u>Target</u> - Extend the impact of the "Know Stroke: Know the Signs. Act on Time" campaign.</p>	<p>Reduce the proportion of heart disease and stroke deaths that occur before transport to emergency services.</p> <p>FY 04: Heart Disease Deaths 45% Stroke Deaths 45%</p> <p>Data Source: US Vital Statistics</p>	<p>Complementary goals, with CDC implementing NIH research findings into practice at the state level.</p>

Appendix B

Changes and Key Improvements

As of December 2002, CDC has achieved or exceeded targets set for 173 of the 217 performance measures in CDC's FY 2001 Performance Report. Only 35 targets were not met, and data is outstanding for 9 of the performance measures contained in the plan. Measures with outstanding data will be reported on as soon as results become available. We anticipate that we will have data available for 7 measures in CY 03 and two measures will not be available until CY 04. However, at this point, CDC has achieved or exceeded 80% of its targets for which data is available.

Numbers tell only part of CDC's performance story. In an on-going effort to improve our performance plan and report, we have recently extensively revised our plan. In fiscal year 2004, CDC plans to address key priorities in prevention and preparedness, while capitalizing on 21st century science and technology to achieve public health goals. In our prevention activities, we will continue our keen focus on closing the gap in health status among racial and ethnic minorities.

In FY 2002, CDC achieved or exceeded a variety of goals in each of the identity theme areas.

Protecting the health and safety of Americans:

- CDC continues to show progress in addressing threats from infectious diseases which remain a leading cause of death worldwide. Coordinators were placed in 48 health departments nationwide to coordinate hepatitis C activities among health department programs. Surveillance for influenza was enhanced nationally to increase the likelihood of early detection of an influenza pandemic and effective tracking of its spread. Significant declines in rates of some foodborne pathogens from 1996 to 2001 have been shown.
- The US has seen dramatic reductions in perinatal AIDS rates in the past decade. In 2001, approximately 100 children were diagnosed with AIDS, down from 954 in 1992. These declines reflect the success of widespread implementation of PHS recommendations for routine counseling and voluntary HIV testing of pregnant women and the use of zidovudine (AZT) by infected women during pregnancy and delivery and for treatment of the infant after birth. Declines may also reflect advances in treatment for those children who have been infected, forestalling progression to AIDS. Revised guidelines were published in 2001.
- The diabetes control programs (DCP) – funded in all 50 states, the District of Columbia, and eight territories – identify high-risk populations, improve the quality of care, involve communities in controlling diabetes, and increase access to care with measurable success. For example of a 2-year period the New York DCP reduced hospitalization rates by 35% and decreased lower extremity amputations rates by 39%. In Michigan a long-standing DCP has produced a 45% lower rate of hospitalizations, a 31% lower rate of lower-extremity amputations, and a 27% lower death rate for participants.

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- The prevalence of current smoking among youth (grades 9-12) decreased from 36.4% in 1997 to 28.5% in 2001. Success in reducing the youth smoking rate is attributed to restrictions on the tobacco industry, increased state funding for tobacco control programs, technical assistance from the federal government to determine effective tobacco-control strategies, and coordination of tobacco-control efforts among public agencies and non-governmental organizations.
- Through September 2001, the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) has provided 3.6 million screening tests to over 1.4 million women. The program has diagnosed 12,000 breast cancers, 48,170 precancerous lesions, and over 800 cases of invasive cervical cancer.
- Because most fire-related deaths and injuries occur while residents are asleep effective detection and alerting systems are essential. Indeed a working smoke alarm can reduce the risk of death by about 50%. In nearly three years CDC's 16-state smoke alarm installation/education program has installed over 116,000 smoke alarms in homes. This program has been credited with saving potentially 346 lives.

Providing credible information to enhance health decisions:

- In FY 2002 CDC continued to expand the information on the amount and types of environmental chemicals that affect people's health. CDC can now measure the presence of approximately 200 such substances including metals, pesticides, dioxins, and others in blood and urine. To communicate these findings to the public, CDC issued the first a *National Report on Human Exposure to Environmental Chemicals* in FY 2001. This report provides the public an assessment of the US population's exposure to environmental chemicals that may cause cancer, birth defects, and respiratory diseases, and other illnesses. Information from this report will also aid in monitoring the effectiveness of programs designed to reduce exposures. The second edition of the *Report* will be released in January 2003.
- The National Program of Cancer Registries includes 45 states, the District of Columbia and 3 territories representing 96% of the U.S. population. CDC helps states and organizations use cancer surveillance data to describe the disease burden, evaluate cancer control activities, and identify populations at high risk for certain cancers. From 1988 through 1999, the California Cancer Registry studied the incidence of cancer among members of the United Farmworkers of America (UFW), a largely Hispanic farmworker labor union. Results showed that the risk of leukemia, stomach, cervical, and uterine cancers was elevated in California farmworkers. UFW members also experienced later stage of disease at diagnosis than other California Hispanics for most major cancer sites, but not for breast cancer. Additional research into the potential causes of this increased risk for certain cancers is planned, including a study of farmworkers' exposure to pesticides.

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- CDC translates occupational research finding into various media for workers, employers, policy makers, and practitioners. CDC distributes >1 million paper copies of documents annually and also makes information available through the NIOSH website. In FY 2002, NIOSH received 10,704 requests for information via the web, 117,500 requests via telephone, and 4,587 requests via mail. To increase its information dissemination efforts to the growing number of Hispanic laborers within the U.S. workforce, NIOSH launched a Spanish version of its website in FY 2002. After its launch in December 2001, the website received 253 requests for information via the web and 157 requests via telephone during FY 2002.
- In FY 2002, CDC documented a 31% reduction in the rate of birth defects of the spine and a 16% reduction in the rate of birth defects of the brain following fortification of the U.S. food supply with the B vitamin folic acid. CDC provided further evidence of the dramatic prevention impact of the vitamin, including a 62% reduction in a common birth defect of the abdominal wall for women who used multivitamins containing folic acid before and during early pregnancy, as well as a 50% decrease in the rate of imperforate anus from a folic acid intervention in China. To make sure that we maximize the prevention impact of folic acid, CDC is also studying whether taking it can reduce risk for women with diabetes, who are known to be at increased risk of having a child with certain birth defects.
- CDC established the Autism Information Center to educate researchers, public health practitioners, parents, policymakers, and the general public about autism and related disorders. The Web-based resource also includes information on autism-related activities conducted or sponsored by CDC and other federal agencies, resources for families and researchers, and activities to help children use the Internet to learn about autism.

Promoting health through strong partnerships:

- Through the Global AIDS Program, CDC is working with experts from US and international agencies such as HRSA, NIH, USAID, CAREC, UNAIDS, WHO, and UNICEF to help ministries of health in Africa, Asia, and Latin America address the devastating impact of HIV/AIDS. In FY 2003, CDC continues to develop programs in 25 countries in Africa, Asia, Latin America and the Caribbean. In addition, CDC will play a key role in implementing the President's International Mother and Child HIV Prevention Initiative. With funds requested in 2003 and 2004, CDC and USAID will work in 14 countries to prevent mother to child transmission of HIV and provide care and treatment to infected mothers to prolong their health and improve family life.

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- As long as polio transmission occurs anywhere in the world, it remains a threat to American children. CDC continues to collaborate with many partners including WHO, Rotary International, USAID, the Task Force for Child Survival and Development, UNICEF, and other international agencies to bolster polio eradication efforts by providing scientific assistance and financial support. This collaboration is unique among public health initiatives for the unprecedented level of partnership. This global initiative is on target for certification of polio eradication by 2005. Global polio incidence has declined more than 99% from 1988 to 2001, about 250,000 lives have been saved and 4 million cases of childhood paralysis have been avoided, and the number of polio-endemic countries dropped from 125 to only 10 at the end of 2001. In FY 2001, a 25% price hike by polio vaccine manufacturers of oral polio vaccine (OPV) from 7.2 cents per dose to 9.0 cents per dose decreased CDC's purchasing capacity (through UNICEF) from a projected 625 million doses in FY 2001 to an actual 590 million doses. For FY 2002, CDC has received increased funding for polio eradication which should allow us to meet the FY 2002 target.
- CDC is partnering with the Christopher and Dana Reeve Paralysis Resource Center to provide a library and Web site with educational materials, referral services, and self-help guidance to those living with paralysis. In its first year of receiving funding from CDC, the center funded more than 60 community programs to improve quality of life for people living with paralysis.
- Through the Special Olympics Healthy Athletes initiative, CDC is partnering with Special Olympics to address health challenges and disparities faced by Special Olympics athletes and other people with mental retardation. The initiative provides quality health services in the areas of oral health, secondary conditions, mental health, nutrition, physical activity, vision, and hearing to address disparities and improve health and well-being among people with mental retardation.
- CDC is partnering with local Muscular Dystrophy Association clinics, Parent Project Muscular Dystrophy and other parent advocacy groups, neurologists, orthopedic surgeons, and others to develop the infrastructure for determining the incidence of muscular dystrophy and evaluating the impact of various treatment options on the health and well-being of people living with the condition.

Appendix B Changes and Key Improvements

High Priority Initiatives in the FY 2004 Plan

Several high-priority, critical initiatives are included in CDC's 2004 Annual Performance Plan. These initiatives include support for the President's Management Agenda, the Secretary's Budget Priorities, and CDC's Workforce Restructuring and Delaying Plan.

CDC's work in support of the Secretary's Budget Priorities includes:

Improved Financial Management

The Program Support section of CDC's Performance Plan represents management activities that cross-cut the entire organization. Activities and priorities of the Human Resources, Information Technology, and Financial Management Offices are all captured in the Program Support section of CDC's Performance Plan.

Preventing disease, illness, and injury with a focus on Healthy Communities

CDC's highest prevention priority is to respond forcefully to the twin epidemics of obesity and diabetes. 2001 saw the release of two landmark, gold standard studies on the prevention of type 2 diabetes in high-risk adults. Both studies show—for the first time—that type 2 diabetes *can be prevented* in very high-risk adults—those defined as “pre-diabetic.”

Ensuring our homeland is prepared to respond to acts of bioterrorism and other health emergencies

CDC will improve its own ability to respond, while also working through its cooperative agreement program to bolster the ability of state and local public health agencies to respond to all terrorism hazards. Research will build our knowledge base.

Realizing the possibilities of 21st century health care

CDC is committed to advancing public health through science and technology. In FY 2004, CDC priorities in this area include building the Public Health Information Network and supporting improved health statistics and geographic information systems.

Appendix C Partnerships and Coordination

Promoting Health through Strong Partnerships

The everyday world provides a series of obstacles to continued good health: emerging infectious diseases and the threat of terrorism (biological, chemical, radiological or through more conventional weaponry); pollution in the air we breathe and water we drink; unsafe conditions in our workplaces; personal habits that damage our health; intentional and unintentional injuries; and limited access to health services, especially for disadvantaged populations. CDC works collaboratively with global, national, state, and local organizations to promote health and protect people from disease, injury, and disability. CDC alone cannot protect the health of the American people. However, by collaborating with others – from state and local health departments to private corporations, from county-sponsored clinics to managed-care organizations, from media outlets to the general public – CDC can leverage its vision of a better world of Safer • Healthier • People.

CDC has a broad mandate to promote health and quality of life by preventing and controlling disease, injury, and disability. The people of CDC contribute significantly to Americans' ability to lead longer, more productive, healthier lives. As illustrated in this report, CDC's unique approach to health improvement achieves results and cost savings. *Safer • Healthier • People* is a desirable and achievable goal made possible by CDC.

Setting the Nation's Health Promotion and Disease Prevention Agenda

CDC has been an active participant in setting and working toward national health promotion and disease prevention goals and objectives since the Healthy People (HP) initiative began in 1979. Beginning in 1996, more than 600 national and state organizations and more than 11,000 persons and organizations participated in the development of HP 2010 objectives. Key participants included representatives of state and local health departments. The extensive participation by representatives of state and local governments, academic institutions, business and labor, and community and professional organizations at each step in the process helped to establish the broad network needed for successful implementation of programs. CDC actively participated in this process, accepting the lead in overseeing the coordination, collaboration, and implementation of many health promotion and disease, injury, and disability prevention objectives.

The HP 2010 initiative was launched in early 2000. CDC shares lead coordination of HP 2010 objectives with other federal organizations. Many of the performance objectives in CDC's Annual Performance Plan are directly linked to HP objectives, and HP 2010 goals and objectives serve as a foundation for a number of CDC's performance measures. Although CDC has lead responsibility for many of the objectives in HP 2010, achievement of these objectives represents a national effort in which CDC works closely with other federal, state, local, and community entities. Performance measures in CDC's plan have been crafted to reflect the collaborative nature of CDC's program activities.

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Supporting State and Local Health Departments

In FY 2000 about 71% of CDC's budget (\$3.07 billion) – provided through extramural grants, cooperative agreements, and program contracts – was spent on public health work performed by CDC's partners. Most of those funds were provided to state and local health departments as grants and cooperative agreements to support public health programs aimed at disease prevention and control.

Supporting Extramural Research

CDC funds extramural research through such programs as the Prevention Research Centers, which support a prevention research agenda at 23 schools of public health throughout the country, and through the community-based, participatory Extramural Prevention Research Initiative, which engages communities in the formulation of research questions and encourages localized application of research findings to prevent disease and promote healthy behavior.

Expanding Partnerships and Coordination

Just as the development of national health objectives is dependent on the work of many, CDC works with its many partners throughout the United States and the world to accomplish the long-term and annual goals in the CDC Performance Plan and the DHHS Strategic Plan. State and local health departments provide the infrastructure on which the public's health is built. Other traditional partners include persons and institutions that educate and promote the health of Americans of all ages, such as school systems, local community groups, businesses, voluntary and professional associations, and other federal organizations. In view of the increasingly diverse and complex role of public health, CDC has reached out to newer and less traditional public health partners, including churches, local organizations, health insurance organizations, health alliances, health boards, consumer groups, and private medical providers.

CDC continues to work with its partners to develop effective outcomes-based control and prevention services.

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CDC Partnership Activities at the Program Level

Birth Defects, Developmental Disabilities Prevention, and Disabilities and Health

CDC works in partnership with state health departments, health care professional organizations, academic institutions, and many non-profit organizations. Specific examples are given below.

Programs for monitoring birth defects, developmental disabilities, and the health of people with disabilities are usually done in partnership with state health departments or with a university or other non-profit organization acting as agent for the state health department. Non-profit organizations such as the March of Dimes will sometimes conduct special surveys on risk factors such as folic acid consumption to assist CDC in monitoring effectiveness of health promotion campaigns. The Early Hearing Detection and Intervention programs are implemented by state health departments but a partner organization, the Directors of Speech and Hearing Programs in State Health and Welfare Agencies, collect and make available the data. Fetal alcohol syndrome (FAS) monitoring is done by state health departments but programs to develop interventions for children with FAS are usually done by universities or other non-profit research organizations. A variety of partners are involved with developing and implementing educational materials about FAS.

Several organization such as the Amputee Coalition of America, the Christopher Reeve Paralysis Foundation, Children and Adults with Attention Deficit Disorder, and National Information Center for People with Disability help CDC provide information to improve the lives of people living with disability.

Chronic Disease Prevention and Health Promotion

Chronic diseases are a community-wide burden. CDC works with state and local health and education agencies, healthcare organizations, academic institutions, national organizations, nonprofit agencies, business, and philanthropies to reduce the burden of chronic diseases.

In fiscal year 2003, CDC will consolidate state funding into six categories of grant programs in fiscal year 2003. These six most closely align with the way programs are organized and implemented in state health departments, and the clustering of state partner organizations that co-fund and implement the programs: (1) *Heart Disease and Stroke*, (2) *Cancer Prevention and Control* (breast and cervical cancer registries, and other cancer grant awards); (3) *Diabetes*, (4) *Health Promotion* (Behavioral Risk Factor Surveillance System (BRFSS), tobacco, nutrition/physical activity/obesity, oral health, arthritis, Safe Motherhood and infancy including Pregnancy Risk Assessment Monitoring System (PRAMS), WISEWOMAN, and any other cooperative agreements not specified above that provide grants for state prevention programs). In addition to the state awards above, consolidated awards will be made to department of education and university partners in the following two areas: (1) *School Health* (Youth Risk Behavior Surveillance System (YRBSS), school-based HIV prevention, and school health programs); and (2) *Prevention Centers*. Over the past year, CDC has consulted with the State Chronic Disease Directors, the Association of State and Territorial Health Officials and the Association of State and Territorial Directors of Health Promotion and Health Education regarding consolidating and streamlining the cooperative agreement process.

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Breast and Cervical Cancer: Recognizing the value of screening and early detection, Congress passed the Breast and Cervical Cancer Mortality Prevention Act of 1990, which established CDC's National Breast and Cervical Cancer Early Detection Program (NBCCEDP). CDC provides funding to all 50 states as well as 20 U.S. territories and tribal organizations to implement the NBCCEDP. The NBCCEDP provides screening services, including clinical breast examinations, mammograms, pelvic examinations, and Pap tests, to underserved women. The NBCCEDP also funds other program components to ensure a comprehensive approach to screening. These include tracking, follow-up and case management; quality assurance; public and professional education; evaluation and surveillance; and partnership development.

Partnerships are critical to the NBCCEDP cancer control efforts. A successful national program to control breast and cervical cancers depends on the involvement of a variety of committed partners and national organizations. The Division of Cancer Control and Prevention at CDC collaborates with state, tribal, and territorial health agencies; health care professionals and organizations; human service and voluntary organizations; and academia.

An example of an important partner to the NBCCEDP is the National Indian Women's Health Resource Center (NIWHRC). The NIWHRC is a national organization whose mission is "to assist American Indian and Alaska Native women achieve optimal health and well being throughout their lives." In October 2000, the Resource Center entered into a cooperative agreement with the CDC's NBCCEDP to provide technical assistance to tribes, tribal programs, and states with substantial Indian populations. The NIWHRC has been a critical partner to supporting screening efforts with Indian populations and building the capacity of funded tribal organizations to implement the NBCCEDP.

Tobacco: It is important to note that while CDC serves as a focal point for DHHS tobacco prevention activities, prevention or reduction of tobacco use is a shared effort. Multiple agencies in DHHS, in addition to CDC, address tobacco use. NIH conducts biomedical and applied research, surveillance, and public health interventions. SAMHSA conducts surveillance and implements regulations on minors' access to tobacco. Other agencies with roles in tobacco policy are the Federal Trade Commission (with oversight of the testing protocol for tar and nicotine yields in cigarettes and the monitoring and regulation of advertising practices), USDA (through their work with tobacco farming communities), Department of Commerce (regarding the manufacturing sector and related businesses), Treasury Department (with customs and taxation issues), and EPA (regarding issues related to secondhand smoke). State and local governments, non-governmental organizations (e.g., American Cancer Society, Robert Wood Johnson Foundation), and healthcare providers also play important roles in efforts to reduce tobacco use. CDC works with community-based programs, health communication campaigns, and schools to prevent and reduce smoking among youth. It is important to note that marketing and other factors (e.g., tobacco advertising, industry pricing patterns, glamorization of tobacco use in the popular media) can counteract efforts to reduce tobacco use.

Community-Based Prevention Research: The PRCs work through established partnerships among state and local health departments, community-based organizations, and other stakeholders to conduct research on a particular theme. For example, CDC is working with NIH's Office of Extramural Research on NIH's Women's Health Initiative, mentioned previously. The PRC program's mission is "connecting science and practice through a network of academic, public health, and community partnerships for scholarly, community-based prevention research, research translation, and education."

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Diabetes: CDC and NIH provide federal leadership for the development, coordination, and implementation of the National Diabetes Education Program (NDEP). CDC has primary responsibility for: coordinating the NDEP Partnership Network of more than 200 organizations, coordinating several of the 10 NDEP planning workgroups, and administering the NDEP community interventions component. CDC collaborates with IHS and other organizations to conduct the research and training activities of the National Diabetes Prevention Center (NDPC). The NDPC was established to address the serious diabetes epidemic in American Indians. CDC's state-based diabetes control programs partner with community health centers to improve the health status of persons with diabetes who receive care at these sites. CDC also collaborates with state health departments, American Diabetes Association, American Public Health Association, Juvenile Diabetes Research Foundation, American Association of Diabetes Educators, and managed-care organizations in the control of diabetes and its complications.

Arthritis: CDC and its principal partners, Arthritis Programs in state health departments and the Arthritis Foundation, are working to increase awareness of arthritis and its impact, and to increase appropriate self management behaviors which have been shown to be effective in reducing pain and improving function. CDC also works with the Arthritis Council of the Chronic Disease Directors Association, and the State and Territorial Directors for Health Promotion and Public Health Education to achieve these program goals.

Cancer Registries: CDC works in conjunction with the National Cancer Institute's Surveillance, Epidemiology, and End Results (SEER) registry program on several cancer related topics. This collaboration, established through a formal Memorandum of Understanding, allows a more coordinated national cancer surveillance effort that builds upon and strengthens the existing infrastructure, improves the availability of high quality data for measuring the nation's cancer burden, and advances the capacity for surveillance research. The CDC also collaborates with the American Cancer Society (ACS), American College of Surgeons (ACoS), North American Association of Central Cancer Registries (NAACCR), and National Cancer Registrars Association. These groups have formed a consortium, the National Coordinating Council for Cancer Surveillance, that encourages and facilitates voluntary reporting of cancer cases from federally supported facilities to state registries. CDC helps states and organizations use cancer surveillance data to describe the disease burden, evaluate cancer control activities, and identify populations at high risk for certain cancers.

Heart Disease & Stroke: CDC has a signed memorandum of understanding with the American Heart Association (AHA), Centers for Medicare and Medicaid Services (CMS), Office of Disease Prevention and Health Promotion (ODPHP), National Institute of Neurological Disorders and Stroke (NINDS), and the National Heart, Lung, and Blood Institute (NHLBI). The purpose of the Partnership formed by this Memorandum is "to catalyze progress toward the goals and targets set forth in the *Healthy People 2010* Heart Disease and Stroke focus area, and improve the health of our communities and our nation...". CDC also partners with the National Stroke Association to increase the awareness of stroke, disabilities and to enhance national stroke surveillance activities. CDC also collaborates with the Health Resources and Services Administration (HRSA) to improve cardiovascular performance measures through improved care delivery systems, increased access, and decreased health disparities among the medically under served populations in federally qualified health centers. Additionally, CDC partners with the Veteran's Administration to develop and institute a system of enhanced computerized clinical reminders, which provides feedback on risk factor

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control and suggests treatment changes to encourage compliance with cardiovascular clinical guidelines. Also, the CDC partners with the American College of Cardiologists (ACC) and the Association of Black Cardiologists (ABC) to enhance provider compliance with guidelines and encourage collaboration with state health departments.

Nutrition, Physical Activity and Obesity: CDC focuses on several strategies to decrease obesity and chronic disease rates by increasing physical activity and good nutrition, mainly through partnerships. Major partnerships on physical activity include the Robert Wood Johnson Foundation's initiative on environmental and policy influences on physical activity, American College of Sports Medicine, U.S. Department of Transportation, National Parks Service, President's Council on Physical Fitness and Sports, and the National Association for Sports and Physical Education. Key nutrition and obesity partnerships include the U.S. Department of Agriculture, National Institutes of Health, American Cancer Society, Produce for Better Health Foundation, American Academy of Pediatrics, and CDC Prevention Research Centers.

Health Statistics

CDC collaborates with the DHHS Data Council, the National Committee on Vital and Health Statistics, representatives from the states, users of CDC data in the public and private sectors, and other federal agencies. Close cooperation with state vital statistics offices ensure timely reporting of data.

HIV, STD, & TB Prevention

HIV/AIDS: CDC works closely with other HHS agencies, including HRSA, SAMHSA, and NIH, to coordinate efforts to address HIV. CDC works with HRSA to evaluate access to care and the extent to which states have been effective in reducing perinatal HIV transmission and provides data necessary for HRSA's care and treatment programs. CDC collaborates with SAMHSA and NIDA on issues related to transmission of HIV in the injecting drug use population. A working group has been established to address healthcare issues in correctional institutions. Development and implementation of the plan to eliminate racial and ethnic health disparities is an interagency effort within DHHS. CDC will expand partnerships with USAID, UNAIDS cooperating agencies (WHO, UNICEF, UNDP, UNFPA), sister agencies in DHHS, other federal agencies, and an anticipated 15 U.S.-based non-governmental organizations working in HIV prevention in Global AIDS countries and regions.

Sexually Transmitted Diseases: CDC works with partners to educate health professionals and the public about the importance of STD prevention, the importance of protective healthcare-seeking and personal sexual behaviors, and the impact of STDs on the health of Americans, particularly women and infants, adolescents, and minority populations. Two major foci of national STD efforts are prevention of STD-related infertility and syphilis elimination.

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Infertility Prevention Program: CDC and the Office of Population Affairs (OPA), Indian Health Service (IHS), and Association of Public Health Labs (APHL) work collaboratively with family planning, STD, and primary-care programs to provide surveillance, screening, treatment, laboratory, and program-relevant research activities to inform and help in the implementation of infertility prevention activities for uninsured and under-insured women.

Syphilis elimination: At least 30% of federal grant funds are provided to non-governmental agencies and organizations that represent and serve affected populations. Among the many national and local partners working to implement syphilis elimination efforts are NIH, HRSA, SAMHSA, NIJ, APHL, and the American Social Health Association (ASHA). Collaborative efforts include: providing technical guidance on clinical services, implementing research and demonstration projects, and promoting collaboration among local affiliates/constituents on elimination efforts. One such example is the Community Health Outreach Education Services (CHORES) collaboration led by HRSA to develop a comprehensive health promotion, health education, and disease prevention program to be integrated into primary care. Five sites selected from CDC-designated high-morbidity areas will focus on implementing prevention into primary care programs and community involvement.

Tuberculosis: CDC works with state, large city, and territorial health departments to deliver TB prevention and intervention activities designed to reduce the incidence of TB and eventually eliminate the disease. CDC works with the HHS Advisory Council for the Elimination of Tuberculosis (ACET), the National TB Controllers Association, American Lung Association, American Thoracic Society (ATS), and Infectious Diseases Society of America to set guidelines, recommendations, and policies related to TB prevention, control, and elimination. CDC is working with the Federal TB Task Force to develop a federal action plan in response to the Institute of Medicine (IOM) report, *Ending Neglect: The Elimination of Tuberculosis in the United States*. CDC works with NIH and FDA to develop new diagnostic and treatment tools and better vaccines. Through contracts with academic institutions and public health departments and interagency agreements (with the Veterans Health Administration), CDC formed a consortium for clinical trials research (currently evaluating the new TB drug, rifapentine) and a consortium for epidemiological and operational research. Internationally, CDC collaborates with USAID, World Health Organization (WHO), and others through efforts such as the Stop TB Initiative and through assistance to specific countries.

Immunization

CDC collaborates with HRSA, CMS, FDA, NIH, and others in achieving immunization objectives.

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Infectious Diseases

To accomplish its mission of protecting the public from infectious disease threats, CDC collaborates with a number of agencies and organizations. Examples of partners and some selected activities include: CSTE (assist states with pandemic influenza planning activities); APHL (enhance state laboratory capacity by providing long-term laboratory training); National Institutes of Health (NIH); Food and Drug Administration (FDA) (food safety programs), USDA (food safety programs), Department of Interior (U.S. Fish and Wildlife), Department of Justice (U.S. Immigrations and Naturalization Service), Department of State, and Department of Treasury (U.S. Customs). To accomplish HCV prevention objectives, CDC collaborates with the National Association of State AIDS Directors (NASAD), National Minority AIDS Council (NMAC), American Social Health Association (ASHA), Pacific Islands Health Officers Association (PIHOA), American Liver Foundation (ALF), Hepatitis Foundation International (HFI), and Indian Health Service (IHS).

Occupational Safety & Health

Through NORA, partnerships have continued between CDC and over 500 organizations to ensure the NORA agenda is implemented. With stakeholder and partnership input, CDC is better positioned to address the toll of workplace injury, illness and death and is assured of having an appropriate research agenda. CDC continues to recruit new partners in occupational safety and health to further engage new stakeholders and increase the knowledge base.

Public Health Improvement

Eliminating Disparities: Development and implementation of the plan to eliminate racial and ethnic health disparities is an interagency effort in DHHS. CDC collaborates with the Office of Public Health and Science, Office of Minority Health, Assistant Secretary of Planning and Evaluation, Agency for Health Care Research and Quality, HRSA, and others in implementing REACH 2010. CDC will also collaborate with federal agencies (to be determined) to implement the component addressing American Indians and Alaska Natives. Specific objectives will be determined through a collaborative interagency process.

Public Health Practice: Since 1997, the Public Health Practice Program Office (PHPPPO) has established an ongoing partnership between Centers for Disease Control and Prevention (CDC) and several national public health (PH) organizations to support special projects that translate the 10 essential PH services into practice. In 2001, the focus of this partnership changed to improve the nation's public health infrastructure. These partner national public health organizations include: American Public Health Association (APHA); Association of State and Territorial Health Officials (ASTHO); National Association of County and City Health Officials (NACCHO); National Association of Local Boards of Health (NALBOH); National Network of Public Health Institutes; and Public Health Foundation (PHF).

These organizations collaborate with various Centers/Institute/Program Offices in a wide area of special projects and activities, including:

- Core activities to improve each partner's infrastructure;
- Refine, field-test, and encourage the use of public health system performance standards;

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- Improve the competency of the public health workforce;
- Improve public health communications and information technology systems;
- Ensure the availability of leadership development programs;
- Review/modify priorities for improving the performance of public health organizations, the workforce, and/or communications and information technology systems;
- Improve the nation's community public health assessment and planning systems;
- Conduct and/or publish research to strengthen the science base of public health practice;
- Translate advances in human genetics into public health practice;
- Improve the capacity of public health agencies to develop and strengthen infectious disease prevention and control programs;
- Improve the development of environmental and occupational public health policy, improve the competency of environmental and occupational public health workers, and broaden and improve the practice of environmental and occupational public health;
- Improve the capacity of public health agencies to effectively respond to chemical and/or biological terrorism;
- Improve the practice of chronic disease prevention and control;
- Improve the capacity of public health agencies to develop and strengthen tobacco prevention and control policies and programs;
- Improve the capacity of public health agencies to implement and/or expand injury prevention and control efforts; and
- Improve the understanding and use of law by public health systems as a tool for effective practice.

In addition to accomplishing the objectives of individual special projects, these cooperative agreements have fostered closer collaboration among organizations that represent the Nation's public health decision makers and practitioners.

CDC facilitates workforce development and targeted training for the public health workforce in conjunction with a variety of public health partners. In collaboration with the Association of Schools of Public Health, CDC has initiated a national network of Centers for Public Health Preparedness (CPHPs) to strengthen emergency preparedness at the front lines by linking academic expertise and assets to state and local health agency needs. Since inception in 2000, the CPHPs, in collaboration with state and local partners, have prepared more than 180 educational products; trained more than 200,000 public health and healthcare professionals; and developed an inventory of faculty expertise and assets available for local, regional, and national emergencies. In addition to the CPHP initiative, CDC partners with the Association of American Medical Colleges (AAMC) to implement projects aimed at linking the disciplines of public health and medicine. Examples of joint efforts include integrating genetics in medical school curricula and initiating the design of regional public health-medicine education centers. CDC's Public Health Training Network (PHTN) is a collaboration of CDC, HRSA, VA, FDA, Department of Agriculture, the Association of Schools of Public Health, and recent partners such as AHA and AMA. PHTN is a distance learning system that takes training to the learner. PHTN uses a variety of instructional media ranging from print-based to videotape, satellite, Internet-based, and multimedia to meet the training needs of the public health workforce nationwide.

Terrorism

Appendix C Partnerships and Coordination

CDC's primary partners in developing national capacity for terrorism preparedness and response are state and local health departments. In addition, CDC works with a variety of federal agencies, academic institutions, and non-governmental organizations, such as Association of Public Health Laboratories (APHL), Food and Drug Administration (FDA), U.S. Army Medical Research Institute for Infectious Diseases (USAMRIID), National Association of County and City Health Officials (NACCHO), National Governors Association (NGA), National Emergency Management Association (NEMA), Infectious Disease Society of America (IDSA) and the Department of Veteran's Affairs (VA). Examples of some of CDC's collaborative activities include: 1) interagency agreement with the Department of Veterans Affairs for procurement of pharmaceuticals and medical supplies that comprise the National Pharmaceutical Stockpile; 2) cooperative agreement with APHL for coordination of the Laboratory Response Network; 3) contract with Acambis, Inc. for development of a new smallpox vaccine; and 4) cooperative agreements with the National Institute for Standards and Technology, the U.S. Army Soldiers Biological and Chemical Command, and the Occupational Safety and Health Administration for the development of respiratory protection standards. Additionally, the National Protective and Personal Technology Laboratory was established, under the National Institute for Occupational Safety and Health. This lab will develop standards and approval processes for respirators to protect against hazardous agents, including chemical and biological weapons of terrorism.

CDC is also partnering with business groups to insure that the private sector is also prepared to deal with public health emergencies.

Appendix D Data Verification and Validation

Data verification and validation help to ensure that the data CDC uses to assess performance is of sufficient quality. The following data systems have been referenced in the CDC Performance Plan as sources for data used in assessing program implementation and effectiveness.

Behavioral Risk Factor Surveillance System

In 1984, CDC initiated the Behavioral Risk Factor Surveillance System (BRFSS), a unique, state-based surveillance system designed to collect prevalence data on behavioral risks and conditions that affect health. States conduct monthly telephone surveys using a standardized questionnaire to determine the distribution of behavioral risk factors. Survey responses are forwarded to CDC, where the data are aggregated and published at year's end. The BRFSS provides flexible, timely, and ongoing data collection that allows for state-to-state and state-to-nation comparisons. Participating states use data derived from the BRFSS to identify demographic variations in health-related behaviors, target services, address emerging and critical health issues, propose legislation for health initiatives, and measure progress toward state and national health objectives. The system's broad network of information gathering also enables states to evaluate their disease prevention and health promotion efforts.

The BRFSS survey instrument is a three-part questionnaire developed jointly by CDC and the states:

1. **Core component:** The *fixed core* is a standard set of questions asked by all states on demographic characteristics and behaviors that affect health (e.g., tobacco use, alcohol consumption). The *rotating core* includes two sets of questions, each asked in alternating years by all states, that address different topics. The *emerging core* consists of up to five questions that typically focus on late-breaking issues. These questions are added to the core for one year and evaluated at year's end to determine their potential value in future surveys.
2. **Optional CDC modules:** These are sets of questions on specific topics (e.g., smokeless tobacco use, arthritis) that states can opt to include in their questionnaires.
3. **State-added questions:** These questions are developed or acquired by participating states and added to their questionnaires.

Each year, states and CDC agree on the content of the core components and optional modules. For ease of comparability and use, many of the questions are taken from established national surveys. More than 30 validity and reliability studies attest to the quality and validity of data derived from the BRFSS.

Appendix D Data Verification and Validation

Clinical Laboratory Improvements Act of 1988 (CLIA)

The Clinical Laboratory Improvements Act of 1988 (CLIA) is designed to ensure the sound and scientific development of new laboratory methods. CLIA includes standards that must be met before certification of a laboratory method. These standards include an exacting series of internal and external evaluations. Among the internal checks is the development of a detailed procedures manual for each method. Manuals must be verified and approved by senior laboratory personnel who were not directly involved in the development of the method. CLIA also provides detailed specifications for quality control and calibration of laboratory equipment. Further internal control is provided through regular review from a designated Quality Assurance Officer tasked with ensuring that generally accepted international scientific standards are being followed in the development of the method. External evaluation and control are provided through regular on-site inspections by statutorily approved, independent inspection teams. Inspectors review the internal procedures established by the organization to ensure compliance with CLIA standards. To date, CDC has passed all on-site CLIA inspections.

Group B Streptococcal Disease Surveillance, part of the Active Bacterial Core Surveillance (ABCs)

In 1989, CDC initiated active surveillance for group B streptococcal (GBS) disease as part of the Active Bacterial Core Surveillance (ABCs) system, an active surveillance system for several pathogens that cause invasive disease. Surveillance was conducted in five geographic areas that were awarded contracts after a competitive request for proposals. In 1994, active surveillance for GBS disease was included as a core activity of the newly established Emerging Infections Program (EIP) network, a cooperative agreement program that addresses important public health issues related to infectious diseases. In 1999, the EIP network comprised eight states; all participated in ABCs and conducted active surveillance for invasive GBS disease.

Specific objectives for GBS disease surveillance are to: 1) assess the impact of CDC prevention guidelines published in May 1996, 2) determine the extent to which continuing cases of early-onset GBS disease are preventable through current prevention strategies, 3) identify serotypes responsible for disease to guide vaccine development, 4) evaluate progress in the elimination of serotype b disease, 5) detect possible emergence of disease due to other capsular types, and 6) determine possible preventable reservoirs of the bacteria. Data collection focuses on disease occurrence. State surveillance officers contact personnel in all microbiology laboratories that process bacterial cultures from sterile sites to find cases of GBS. Laboratory audits are also conducted semi-annually to detect possible underreporting. Data are transmitted electronically from the EIPs to CDC's ABCs team on a monthly basis. Annual surveillance reports are made available on the Internet at the ABCs website. Laboratory testing of isolates collected as part of surveillance is performed in reference laboratories. Electronic files containing results of laboratory testing of each state's isolates are fed back to that state on a monthly basis.

Appendix D Data Verification and Validation

Routine laboratory audits to ensure the completeness of data collection represent a tremendous strength of the system. Each month, CDC staff review data and transmit potential errors to state personnel for evaluation. Performance standards for active surveillance have been established in each site to permit aggregation of data collected via somewhat different approaches. Detailed instructions for completion of case report forms ensure consistency across sites. State surveillance officers and CDC's ABCs team hold monthly conference calls to address logistical and technical aspects of the system and meet annually to review and update protocols, present special studies, and discuss innovations. Site visits are currently conducted on an as-needed basis, but annual site visits are planned.

Easy access to the data is provided through a website that includes the basic protocol and one-page yearly surveillance reports for each pathogen. Additional information on GBS is available on a website focused on that infection, with many materials targeted to pregnant women or healthcare providers and public health workers concerned with pregnant women.

The principal limitation of GBS disease surveillance through the ABCs is that it is not conducted throughout the United States. Substantial geographic variation in the incidence of invasive GBS disease has been noted, and it is unclear whether states outside ABCs areas have experienced changes in the incidence of GBS disease that are comparable to those noted in the surveillance areas. One way of addressing this limitation is to increase the availability of ABCs methods and tools. Through the website and frequent publications, CDC is attempting to provide other state health departments with information that can help them assess whether the efforts involved in conducting invasive GBS disease surveillance, particularly for early-onset disease in infants <7 days, are feasible in their locales.

Integrated Resources Information System

CDC's Integrated Resources Information System (IRIS) is a collection of applications to assist management in budget, staffing, and project planning, tracking, and reporting. The IRIS budget application provides detailed budget information by CDC component. It allows managers to view budget reports grouped by a variety of options. IRIS staffing is a view-only application designed to allow users to quickly access personnel data reports and project employee salaries for a specified time period. The projects application allows managers to plan, track, and manage various types of projects. This application provides access to project data, resources, and administrative functions. All information for a project must be maintained in the IRIS projects component to ensure consistency and reliability of data. The IRIS reports application is the data retrieval and reporting component.

Appendix D Data Verification and Validation

National Health and Nutrition Examination Survey

The National Health and Nutrition Examination Survey (NHANES) is a program of studies to assess the health and nutritional status of adults and children in the United States. Started in the early 1960s, NHANES is the only national source of objectively measured health data capable of providing accurate estimates of both diagnosed and undiagnosed medical conditions in the population. Findings from the survey are essential for determining rates of major diseases and health conditions and for developing public health policies and prevention interventions. The survey screens 15,000 households per year and selects 3,500. From this sample, 5,000 persons are interviewed and examined annually. Samples are recruited from 15 counties or clusters of counties each year. Samples comprise sufficient numbers to provide reliable estimates by gender and age group for non-Hispanic whites, Mexican Americans, and African Americans.

Data are collected via health interview, physical examination, and clinical and laboratory tests. Interviews are conducted in respondents' homes. Physical examinations are performed in specially designed mobile examination centers that travel to survey locations throughout the country. These centers allow for the collection of data on chronic conditions, nutritional status, medical risk factors, dental health, vision, illicit drug use, blood lead levels, food safety, and other factors that are not possible to assess by use of interviews alone. The medical team consists of a physician, dentist, medical and health technicians, and dietary and health interviewers; trained bilingual staff conduct the household interviews.

An advanced computer system using high-end servers, desktop PCs, and wide-area networking is used to collect and process all NHANES data, nearly eliminating the need for paper forms and manual coding operations. Household interviewers use notebook computers with electronic pens for data collection in the field. Data collected in the mobile examination centers are automatically transmitted via a frame relay network into central databases. Survey information is available to CDC within 24 hours of collection.

Information from NHANES is disseminated through an extensive series of publications and articles in scientific and technical journals. Survey data are also available on CD-ROM and computer diskettes. In previous years, data were available for analysis approximately 31 months after collection. A goal is to improve the timeliness of data dissemination. The computerized system has already substantially improved access to the data from the field.

A comprehensive quality assurance program is instituted before data collection begins, with appropriate training that requires significant practice time for the health examiners and interviewers. Training focuses on hands-on experience rather than didactic methods. During data collection, health examiners and survey staff meet regularly to discuss operations, updates, and problems. Staff are retrained as needed.

Appendix D Data Verification and Validation

NHANES relies on both passive and active monitoring systems for operational and content-related quality control. Passive quality control uses automated computer procedures for detecting data anomalies. After careful analysis, appropriate activities can be undertaken to resolve any data collection issues. Active quality control relies on examiner feedback to identify and evaluate problems and select remedies. NHANES primarily relies on physical measurements from well-established biomedical procedures. In most instances, these measurements represent the gold standard data against which self-reported data might be validated for other subjective data collection modalities. New technologies under consideration are evaluated to determine if they provide valid estimates of the condition, risk factor, or measurement for which they are being used. The evaluation might include a scientific literature review, expert workshop, or validity study.

National Health Interview Survey

The National Health Interview Survey (NHIS) is the principal source of information on the health of the civilian, non-institutionalized population of the United States. The purpose of the NHIS is to monitor the health of the U.S. population through the collection and analysis of data on a broad range of health topics. A strength of the survey is the ability to display these health characteristics by many demographic and socioeconomic factors. NHIS data are used widely throughout DHHS to monitor trends in illness and disability and to track progress toward achieving national health objectives. The data are also used by the public health research community for epidemiologic and policy analysis.

The NHIS is a cross-sectional household interview survey. Sampling and interviewing are continuous throughout each year. Households chosen for interviews are a probability sample representative of the target population. NHIS data are collected annually from approximately 43,000 households including about 106,000 persons. Survey participation is voluntary, and the confidentiality of responses is ensured. The annual response rate is >90% of eligible households in the sample.

The NHIS has three modules:

- The basic module remains largely unchanged from year to year and allows for trend analysis. Data from more than one year can also be pooled to increase the sample size for analytic purposes. The basic module contains a family core, a sample adult core, and a child core through which data are collected on the family unit and from one randomly selected adult and child.
- Periodic modules collect more detailed information on some of the topics included in the basic module.
- Topical modules respond to new data needs as they arise.

Appendix D Data Verification and Validation

Data are collected through a personal household interview conducted by staff employed and trained by the U.S. Bureau of the Census according to procedures delineated by CDC. Data are reviewed and analyzed extensively to ensure their validity and reliability. The survey sample is designed to yield estimates that are representative and that have acceptably small variations.

Before the actual survey, cognitive testing is performed by CDC's Questionnaire Design Research laboratory, and pretests are conducted in the field. Once collected, data are carefully edited, checked, and compared to data from earlier surveys and/or independent sources. Staff members calculate descriptive statistics and perform in-depth analyses, which result in feedback on the analytic usefulness of the data.

In the past, it has taken approximately 26 months for the survey data to be released for a given year. Improving the timeliness of NHIS data is a GPRA performance measure.

National Hospital Discharge Survey

The National Hospital Discharge Survey (NHDS), conducted annually since 1965, is a national probability survey designed to meet the need for information on characteristics of inpatients discharged from non-federal, short-stay hospitals in the United States. The NHDS collects data from a sample of approximately 300,000 inpatient records acquired from a national sample of about 500 hospitals. The NHDS provides national and regional estimates of U.S. inpatient hospital utilization by the demographic characteristics of patients discharged, conditions diagnosed, and surgical and non-surgical procedures performed. Approximately 95% of eligible sample hospitals respond to the survey.

The NHDS uses two data collection methods: 1) a manual system in which hospital staff or staff of the U.S. Bureau of the Census abstract data from medical records, and 2) an automated system in which CDC purchases machine-readable medical record data from commercial organizations, state data systems, hospitals, or hospital associations. Approximately 40% of hospitals provide data through the automated system. Data are generally available about 17 months after collection. Timeliness is being addressed as part of the GPRA effort.

An ongoing quality control program helps to ensure the accuracy of NHDS data. NHDS data have been found to be a good reflection of information found in medical records. What is not known is the degree to which medical record information reflects actual performance.

Appendix D Data Verification and Validation

National Immunization Survey

The Childhood Immunization Initiative (CII) is one of many federal, state, and local programs mounted to raise vaccination levels in young children. The CII established a 1996 goal of increasing vaccination levels for 2-year-old children to at least 90% for measles-mumps-rubella, diphtheria and tetanus toxoids and pertussis vaccine, oral poliovirus vaccine, and *Haemophilus influenzae* type b vaccine. In addition, the CII established a goal for 1996 to increase vaccination levels for 2-year-old children to at least 70% for three or more doses of hepatitis B vaccine.

The National Immunization Survey (NIS) is used to assess progress towards these goals. NIS data provide current, population-based, state and local estimates of vaccination coverage produced by a standard methodology. Quarterly data are collected via household interviews in 50 states, the District of Columbia, and 27 urban areas. Interviews are conducted by telephone with randomly selected households. Each quarter, CDC calculates estimates of vaccination coverage levels and makes valid comparisons of state efforts to deliver vaccination services. CDC uses NIS data to evaluate progress towards national vaccination goals and to identify states with the highest and lowest immunization rates.

To ensure the accuracy and precision of coverage estimates, immunization data for surveyed children are also collected through a mail survey of their pediatricians, family physicians, and other healthcare providers. The parents and guardians of NIS-eligible children are asked during the telephone interview for consent to contact childrens' medical providers. Types of immunizations, dates of administration, and additional data about facility characteristics are requested from immunization providers identified during the telephone survey of households. NIS estimates of vaccination coverage therefore reflect a comparison of information provided by both immunization providers and households.

National Vital Statistics System

Vital statistics are often the most complete and continuous information available to public health officials at the national, state, and local levels. The National Vital Statistics System is responsible for the nation's official vital statistics. The registration of vital events – births, deaths, marriages, divorces, fetal deaths – is a state function, and vital statistics are provided through state-based registration systems. Since 1902, the federal government has obtained use of the records for statistical purposes through cooperative arrangements with the responsible agencies in each state. Standard forms for the collection of data and model procedures for the uniform registration of events are developed and recommended for state use through cooperative activities of the states and CDC. CDC also provides training and instructional materials to the states as part of ongoing technical assistance.

Appendix D Data Verification and Validation

The purpose of collecting the data is to monitor trends over time through vital life events. Vital records and reports originate with private citizens, such as the family affected by the events, physicians, or funeral directors. By law, birth registration is the direct responsibility of the hospital of birth or the attendant at the birth. In the absence of an attendant, the parents of the child are responsible for registering the birth. Although procedures vary from hospital to hospital, personal information is usually obtained from the mother; medical information may be obtained from the chart or from a worksheet completed by the birth attendant. Reporting requirements vary from state to state; in general, the completed certificate must be filed with the state or local registrar within 10 days of birth. Published data represent all counties and places of 10,000 or more population. Electronic files include data for states, counties, large cities (population of 100,000 or more), and metropolitan statistical areas.

By law, death registration is the direct responsibility of the funeral director or person acting as such. The funeral director obtains the data required, other than the cause of death, from the decedent's family or other informant. The attending physician provides a best medical opinion about the cause and manner of death; later this information is coded by the state or CDC according to uniform codes. Demographic information is also recorded. If no physician was in attendance or if the death was due to other than natural causes, the medical examiner or coroner investigates the death and provides the cause and manner. Reporting requirements for death vary, but in general the completed certificate must be filed within 3 to 5 days of the death. Published data include all counties and places of 10,000 or more population. Electronic files include data for states, counties, large cities (population of 100,000 or more), and metropolitan statistical areas.

Fetal deaths are also reported through the National Vital Statistics System. All fetal deaths of 20 weeks or more gestation that occur in the United States are recorded. A linked birth/infant death file allows for the analysis of demographic and health characteristics from certificates of live births in combination with causes of death and other data from death certificates of infants who died before their first year of life. The linked file set includes information on all the infants who died in the United States each year, as well as information on all live births. An additional file includes information on death records not linked to birth certificates. The match rate is about 97%-98%. Data are organized by calendar year.

Provisional and final estimates of the number of marriages and divorces are obtained from each state able to provide these figures. Since data are not available from all states, national divorce rates are not produced. Detailed characteristics of marriages and divorces have not been available since 1996.

Vital statistics data are collected using uniform procedures and are accurate and consistent. The data are reported as soon as they are analyzed by CDC staff. Monthly provisional numbers and rates are published in the *National Vital Statistics Reports*. These figures are based on approximate counts of the number of events that occurred in a given state; an estimation procedure is used to convert these occurrence estimates into state-specific estimates of the number and rate of resident events. Preliminary data collected through the National Vital Statistics System are made available to the public approximately 10 months after the end of the collection year. Data are presented for a 12-month period and are published semi-annually in the *National Vital Statistics Reports*. Final data are released about 18 months after collection via *National Vital Statistics Reports*, public use data tapes, CD-ROM, Series Reports, the Internet, and journal articles. Use of electronic products have greatly increased the accessibility of the data and reduced the costs to researchers and other users.

Appendix D

Data Verification and Validation

The data collected through the National Vital Statistics System represent all registered vital events in the United States and adequately represent the true rates of events. To more accurately record birth and death information, new birth and death certificates are being designed through a collaborative effort with states, researchers, and other interested parties. The revised certificates reflect changing data needs and emerging public health applications; they will be implemented in 2003.

Sentinel Surveillance for Chronic Hepatitis C

Although a large number of persons in the United States are chronically infected with HCV and many will develop chronic liver disease, the burden of disease has not been well characterized. There is no ongoing surveillance, and few population-based studies have been conducted from which to determine the incidence and prevalence of chronic liver disease and the relative proportion of cases attributable to viral hepatitis and other etiologies. To begin to collect this information, CDC established a pilot surveillance system for chronic liver disease in 1998. The data-collection system has three components:

- A standard interview questionnaire, developed by CDC, is used by all sites to ensure comparability of data and facilitate aggregation of data as appropriate. The instrument includes questions from other established surveillance systems and from previous studies of chronic liver disease. Questions focus on demographic characteristics, clinical information, quality of life issues, and exposures and risk factors.
- A standard form is used to abstract clinical and laboratory information from the patient's clinical chart. This information, collected consistently across sites, includes data needed to determine disease etiology, treatment history, medication use, and other relevant clinical information.
- A serum sample is collected and sent to CDC to identify serologic markers for viral hepatitis.

An important characteristic of the pilot is its comprehensiveness. For the first time, all patients with chronic liver disease in several geographic areas are being identified using a common methodology, with consistent information collected in all sites. The goal is to expand the use of the methodology and data collection instruments to other sites throughout the United States to develop a comprehensive picture of the occurrence and characteristics of chronic liver disease and to monitor trends.

Although quality assurance and quality control instruments are still under development, several validation studies have been conducted. To assess the completeness of reporting, CDC conducted a survey of primary care practitioners and a review of all first-time liver biopsies. These studies indicated that overall surveillance was comprehensive and was successful in identifying the vast majority of patients in the target population. A review of a randomly selected subset of charts failed to reveal any significant errors in chart abstraction. To assess the overall validity of the study, early preliminary results have been compared to the few existing relevant data. This evaluation, demonstrating that the incidence of newly diagnosed chronic liver disease has increased in recent years, is already contributing to CDC's efforts to more accurately estimate the burden of illness from chronic liver disease.

Appendix D Data Verification and Validation

U.S. Sentinel Physician Surveillance for Influenza

Established in 1982, the U.S. Sentinel Physician Surveillance for Influenza is one of four primary sources of influenza surveillance data. The sentinel physician surveillance system is an active system of surveillance conducted from October through May. Each week during that period, several hundred volunteer physicians around the country report the total number of patients seen and the number of those patients with influenza-like illness by age group.

During the 1997-98 influenza season, 27 states and the District of Columbia elected to participate in a pilot program to upgrade the sentinel physician surveillance system. The pilot merged CDC's national sentinel surveillance system and state-based systems into one integrated system based on common methodologies and standards. During the 1998-99 influenza season, the enhanced sentinel physician surveillance system was expanded to include 40 states and the District of Columbia, and an Internet reporting system was developed. States are responsible for establishing, recruiting, and maintaining state-based sentinel physician groups and for ensuring that data are collected and transmitted regularly to a central data repository at CDC, which is updated daily. CDC is responsible for coordinating the system nationally, maintaining the reporting systems, processing and analyzing the data, and maintaining the Internet site. Efforts to improve the system are continuous.

Sentinel physicians can report data via any of three methods: 1) Internet reporting, 2) touchtone phone reporting, or 3) facsimile transmission with manual entry of data. A program developed by CDC integrates the three sources of data and uploads the data to the Internet site. Data are available daily to each state coordinator. A summary of influenza activity is available to the general public each week.

CDC has undertaken a continuous process to simplify use of the system, clarify case definitions, and offer multiple options for input and access. With daily updates and weekly summaries, the information is extremely timely and pertinent for decision making. CDC epidemiologists analyze the data for outlying information and perform routine checks for coherence. State coordinators routinely check the timeliness of reporting and troubleshoot problems at the local level. Guidelines are provided to sentinel physicians for optimal timing of specimen collection for virologic testing on certain patients. There is no way to ascertain that the data on influenza-like illness is free of error, but, as the number of participating sentinel physicians increases, the potential consequences of errors decrease. Given that sentinel surveillance provides an index of current influenza activity, consistent reporting by a stable group of physicians is imperative for data reliability. Increasing sentinel physician sites and sentinel physician participation in each state would greatly increase the validity of the data.

Appendix D Data Verification and Validation

Youth Risk Behavior Surveillance System

CDC established the Youth Risk Behavior Surveillance System (YRBSS) in 1990. One of the components is a national school-based survey that was first conducted in 1990 and has been repeated biennially since 1991. The national Youth Risk Behavior Survey (YRBS) measures six categories of priority health risk behaviors that contribute to the leading causes of mortality and morbidity among youth and adults in the United States: 1) behaviors that may lead to violence and unintentional and intentional injuries; 2) tobacco use; 3) alcohol and other drug use; 4) sexual behaviors that contribute to HIV infection, other sexually transmitted diseases and unintended pregnancy; 5) unhealthy dietary behaviors; and 6) inadequate physical activity.

The YRBS is administered in the spring to nationally representative samples of students in grades 9-12 attending both public and private schools. Professional data collectors, trained specifically for the YRBS, are used as field staff to ensure standard administration procedures. The YRBSS uses a three-stage cluster sample to select schools and classes of students within schools. African-American and Hispanic students are oversampled to provide accurate estimates for these subgroups in each survey cycle. By combining data from multiple survey cycles it is also possible to obtain accurate estimates for Asian and Native American youth. The sample size totals approximately 14,000 students per survey. School response rates average 76%; student response rates average 88%.

The YRBS questionnaire is designed for self-administration by use of a computer-scannable booklet. The questionnaire has been modified as needed to address emerging public health problems. A reliability study of the questionnaire conducted in 1993 demonstrated that students reported health risk behaviors reliably over time. Psychometric work has demonstrated that the questionnaire yields accurate and high-quality data. Standardized data editing and cleaning procedures improve data accuracy and consistency. Data are released within 12 months of data collection and are made available to the public via the Internet.

Appendix D Data Verification and Validation

CDC Program-Specific Data Verification and Validation

Birth Defects, Developmental Disabilities Prevention, and Disabilities and Health

For the goal to prevent birth defects and developmental disabilities, the performance measures use data from CDC's Behavioral Risk Factor Surveillance System, the National Birth Defects Prevention Network, the number of maternal interviews entered into the National Birth Defects Prevention Study, the Alliance for Research in Child Health Epidemiology, and the count of specific types of studies funded by CDC.

For the goal to improve the health and quality of life of Americans with disabilities, the performance measures are simple counts of programs, publications, and data from a database maintained by the Directors of Speech and Hearing Programs for State Health and Welfare Agencies.

Chronic Disease Prevention and Health Promotion

Early Detection of Breast and Cervical Cancer: CDC uses the Minimum Data Elements (MDEs) to report on all GPRA measures. States, territories, and tribal organizations (NBCCEDP grantees) submit MDEs electronically twice a year (January 15 and July 15) to a data management contractor, who analyzes the data and submits a data file to CDC. These files are made available in April and October. CDC will use the January 15 submission to report performance for the new GPRA measures. Data provided in the performance report include only screening exams through March 31 of the previous year to allow adequate time to gather the data and present a complete program report. NBCCEDP grantees are provided 9½ months after the initial screening date (March 31) to gather diagnostic and treatment information and prepare the data submission by January 15. The data management contractor analyzes the data by March and sends the report to CDC. All data collected and submitted by NBCCEDP grantees have indicators to assess completeness. Data are also assessed against established clinical standards.

Tobacco: CDC monitors cigarette use among youth and reports performance on a biennial basis using the Youth Risk Behavior Survey (YRBS), which is a component of the YRBSS (see Appendix A.2). Three additional surveys, the National Household Survey on Drug Abuse (NHSDA) the Monitoring The Future (MTF) Survey, and the National Youth Tobacco Survey (NYTS), provide complementary data for examining trends and understanding youth-related tobacco issues. The NHSDA is conducted annually by SAMHSA; the MTF is conducted annually by the University of Michigan's Institute for Social Research; and the NYTS is currently conducted by the American Legacy Foundation, but will transfer to CDC in 2004.

Community-Based Prevention Research: Data are available from grantee progress reports and will be verified through site visits and publications. CDC program consultants validate information received through site visits and telephone consultations. No data lags are expected.

Heart Disease & Stroke: CDC will evaluate stroke registry capacity via annual state reports, deaths from heart disease and stroke via death certificate data from states, and uncontrolled high blood pressure data from HRSA.

Appendix D Data Verification and Validation

Diabetes: CDC verifies performance through quarterly state reports and periodic site visits. For efforts in American Indian/Alaskan Native populations, data are verified via program reports and documentation of support. The BRFSS collects data on receipt of annual eye and foot exams in persons with diabetes.

Arthritis: CDC collects and evaluates data on state-based arthritis programs via annual state program reports and site visits.

National Cancer Registries: Participating states are expected to collect information on at least 95% of cancer cases diagnosed or treated in their state each year. NPCR funded states are required to incorporate NAACCR standards for data quality and format. States report de-identified cancer case data annually to a CDC contractor. In addition, CDC receives regular reports from each state which summarize progress of completeness, timeliness, and quality of registry data. NPCR staff also prepare annual internal evaluations of program progress.

Variations in states' capacities (planning or enhancement status) and initial funding year result in differences across reference years used for calculating registry data completeness. NAACCR has established a process by which states can apply for certification to ensure that member registries are collecting useful and high-quality data. Member registries are evaluated yearly and provided confidential feedback. Data for FY 2001 will be available in June 2002 for reporting.

HIV Prevention among School-aged Youth: Data are collected on a biennial basis (during odd-numbered years) through CDC's YRBSS, a system designed to focus attention on priority behaviors among youth that are associated with the most important health problems (see Appendix B). The YRBSS was developed in partnership with federal agencies, state departments of education, scientific experts, and survey research specialists. The YRBSS includes separate national, state, and local school-based surveys of high school students. A recent study provides evidence that this adolescent survey has good reliability in measuring health behavior. Baseline data from the 1995 YRBSS are used because: 1) they were the most recent data available when the original measures were created, and 2) they will allow a more accurate illustration of trends in sexual behaviors over time.

Nutrition/Physical Activity and Obesity: CDC plans to collect and evaluate state data on nutrition and physical activity programs via annual state program reports, site visit reports, and a program evaluation database.

Environmental Health

Environmental Health Laboratory/Biomonitoring: All analytical methods developed must be certified under the Clinical Laboratory Improvements Act of 1988 (CLIA).

Appendix D Data Verification and Validation

Data systems at CDC's Environmental Health Laboratory monitor laboratory performance under CLIA. CDC also conducts quality assurance activities internally to confirm results and ensure their validity. CLIA-approved methods are used to analyze levels of environmental chemicals published in the *National Report on Human Exposure to Environmental Chemicals* that are measured in specimens obtained from the National Health and Nutrition Examination Survey (NHANES). The use of CLIA-approved methods is verified by senior staff as well as by internal quality assurance officers. The sample size and control mechanisms for the *Report* have been established as part of NHANES.

Asthma: Data verification is based on required reporting by grantees. CDC project officers will verify that states are fulfilling the requirements of cooperative agreements through routine monitoring of the grants process. CDC epidemiologists will review all statistical and surveillance data to ensure appropriate application of statistical and epidemiologic methods.

Health Statistics

CDC will verify performance via contractor reports, pretest reports, meeting proceedings, publications, and website records.

HIV, STD, and TB Prevention

HIV/AIDS Data Collection Systems: CDC uses multiple data collection systems to monitor HIV trends and prevention programs. The HIV/AIDS Reporting System (HARS) collects case reports of HIV-infected persons in state and local health departments. AIDS case data are available from all states and territories using uniform name-based collection methods (—no names or personal identifiers are sent to CDC; these are maintained only at the local level). Although completeness of reporting of diagnosed AIDS cases varies by area and patient population, studies indicate that reporting in most areas is more than 85% complete. Reporting of AIDS deaths is estimated to be more than 90% complete. In contrast, HIV data collection systems vary between areas (e.g., name-based code, coded identifier, name-to-code, etc. data collection systems). CDC is conducting validation and evaluation studies of these systems to determine the quality of data generated by them. Currently, trends in HIV diagnoses for adults and adolescents are available only from 25 states which have implemented name-based HIV case reporting (using methods similar to those for AIDS case reporting) since at least 1994.

The period of time between a diagnosis of HIV or AIDS and the arrival of a case report at CDC is called the "reporting delay" (40% of AIDS cases are reported to CDC within 3 months of diagnosis, 80% within 1 year). In order to provide the best estimates of trends in incidence, HIV and AIDS surveillance data are analyzed by the date of diagnosis and are mathematically adjusted in more recent periods to adjust for reporting delays and incomplete information on some cases. CDC requires a minimum of 18 months after the end of a calendar year to provide accurate estimates of trends for through that year. For example, calendar year 2000 data will be available in the summer of 2002.

Appendix D Data Verification and Validation

In addition to the HARS data, CDC has supplemental surveillance systems to collect in depth information on HIV/AIDS cases and prevention programs. The Supplement to HIV/AIDS Surveillance (SHAS) project collects interview information from recently reported HIV/AIDS cases ≥ 18 years of age in 16 state/local health department jurisdictions on their sex and drug using behaviors, access to and adherence to care, and utilization of prevention interventions. The Adult and Adolescent Spectrum of HIV Disease (ASD) study collects longitudinal medical record review data on antiretroviral therapy, clinical care, and outcomes from HIV-infected persons receiving care in selected medical facilities in 9 areas; most of these facilities are publicly-funded. The HIV Counseling and Testing System (CTS) collects the number of tests performed, demographic and characteristics, test results, and utilization of post test counseling services in publicly-funded sites in all states.

Surveillance reports and in depth analyses of data from these systems are available upon request from CDC.

Sexually Transmitted Diseases: TD incidence and prevalence data (hardcopy and electronic) undergo ongoing verification and validation procedures including quarterly reports back to project areas comparing reporting across all data sources, trend information, percent unknowns for clinical fields, edit checks and updates, as well as constant communication via fax, phone, and email with project staff. PID hospitalization data is collected through the National Hospital Discharge Survey conducted by the National Center for Health Statistics, and PID initial visits to physicians is collected through the National Diagnostic and Therapeutic Index by IMS America, Ltd. Additional feedback is provided to project areas via annual publications and reports.

Prevention of STD-Related Infertility: Data on the prevalence of chlamydial infection in defined populations have been useful in monitoring disease burden and guiding screening programs. In particular, CDC monitors trends in prevalence among women enrolled in the U.S. Department of Labor National Job Training Program and among women screened for chlamydia attending family planning clinics. These programs provide crucial information on the prevalence of chlamydia in high-risk populations, i.e., young sexually active women. Data from these programs indicate that: 1) chlamydia is geographically widespread (in nearly all states, chlamydia positivity exceeded the Healthy People 2010 objective of 3%), and 2) younger women (<24 years of age) consistently have higher chlamydia positivity than older women. Chlamydia screening is not as widespread for men. Chlamydia prevalence was 4.7% among men aged 17-37 years who were screened at entry in the U.S. Army in 1999-2000. Although these prevalence data are not entirely comparable because of differences in the performance characteristics of screening tests and variations in screening criteria, they provide important information on the continuing high burden of disease. The data also allows monitoring of chlamydia in multiple venues and populations which is critical to understanding the true burden of disease.

In efforts to reduce the prevalence of chlamydia among high-risk women under age 25, CDC does not have activities targeted specifically to Job Training Program participants. However, CDC includes data provided by the U. S. Department of Labor because the data are an important component of assessing burden of disease. National Job Training Program participants, who are required to be screened for chlamydia at program entry, represent an important high-risk population CDC is trying to reach, young sexually active women. Continued expansion of chlamydia screening should lead to a continued reduction of the burden of disease among women, including National Job Training Program participants. For economically

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disadvantaged women aged 16 to 24 years who entered the National Job Training Program from 27 states, and Puerto Rico, in 2001, the overall prevalence was 10.6 %. Given that there has been little or no change in the prevalence of chlamydia among the National Job Training Program participants, and given that CDC does not have activities specifically targeting the National Job Training Program, the target has been adjusted to 10% for 2002 and 9% for 2003 and 2004.

In 2001, CDC achieved the goal of reducing chlamydia prevalence among women attending family planning clinics. Unlike the measure that utilizes data from the U.S. Department of Labor's National Job Training Program, this measure reflects the performance of long-standing, widespread CDC-supported screening programs. The median state-specific positivity was 5.6% for women aged 15 to 24 years screened at selected family planning clinics in all states and outlying areas. In selected prenatal clinics in 22 states and Puerto Rico, the chlamydia prevalence was 7.4%. After adjusting trends in chlamydia positivity to account for changes in laboratory methods and associated increases in test sensitivity, chlamydia test positivity among women decreased in five of 10 DHHS regions from 2000 to 2001, increased in four regions, and remained the same in one region. Although chlamydia positivity has declined in the past year in some regions, continued expansion of screening programs to populations with higher prevalence of disease may have contributed to the increases in positivity seen in other regions.

As CDC continues to expand its efforts, data from the family planning clinics is crucial not only in measuring performance but also in guiding future efforts. Effective interventions have been demonstrated, but they are not reaching all those in need. Achieving future declines in chlamydia prevalence hinges upon efforts to: 1) expand chlamydia screening and treatment services so they are easily available to both men and women; 2) increase awareness about chlamydia testing and treatment services at private clinics and doctors' offices; and 3) expand health promotion activities.

Gonorrhea: The U.S. experienced a 73.9% decline in the reported rate of gonorrhea in the U.S. from 1975 to 1997. The rate increased in 1998, but the rates of reported gonococcal infections have since been steady (128.5 in 2001, 129.0 in 2000, 132.3 in 1999, and 131.9 in 1998). The 2001 rate exceeds the Healthy People 2010 objective of 19 cases per 100,000 persons.

Although reported rates of gonorrhea were once substantially higher among men than women, that gap has narrowed. This is most likely due to increased screening in women. Because women are more likely to be asymptomatic than men, cases in women are less likely to be identified and reported. The overall gonorrhea rate in U.S. females in 2001 was similar to the rate in 2000 (128.2 and 126.7, respectively). The gonorrhea rate in men was similar with 130.9 and 128.4 cases per 100,000 males in 2000 and 2001, respectively. Among women aged 15-44, the 2001 rate was 286 per 100,000, exceeding the target rate of 250. In 2001, 15- to 19-year-olds had the highest rate (703.2 cases per 100,000 females) of gonorrhea among women. Among men, rates (563.8 cases/100,000 males) were highest among 20- to 24-year-olds. Profound racial disparities persist for gonorrhea, with 2001 reported rates among non-Hispanic blacks about 27 times higher than among whites and Hispanic rates almost 3 times higher than rates among whites. This disparity most likely reflects differences in access to prevention and treatment services.

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Although increased screening, use of more sensitive diagnostic tests, and improved reporting may account for a portion of increase in the recent past, true increases in disease in some populations and geographic areas also appear to have occurred. The southern states continue to have the highest gonorrhea rates of any region. Reasons may include poverty levels and access to quality healthcare and preventive services. Future declines in gonorrhea prevalence will require efforts to 1) increase public and provider awareness of the problem, 2) increase screening and treatment in high-risk populations, and 3) expand health promotion and prevention.

Pelvic Inflammatory Disease (PID): The decrease in the incidence of PID is possible evidence of intensified nationwide screening and treatment efforts for chlamydia, a principal cause of PID. The incidence of hospitalization for PID among women aged 15-44 decreased from 127 per 100,000 women in 1999 to 120 per 100,000 women in 2000, achieving the 2000 target of 125 per 100,000 women. These decreases in hospitalizations may also be attributable to an increasing trend of outpatient management for PID and increased use of oral treatments.

The reported number of initial visits to physicians' offices for PID through the National Disease and Therapeutic Index (NDTI) has generally declined from 1993 through 2001 but is still higher than the 2001 target of <225,000 visits.

Accurate estimates of PID and tubal factor infertility from gonococcal and chlamydia infections are difficult to obtain. Definitive diagnosis of these conditions often requires complex surgical or other diagnostic tests. Most cases of PID are treated on the basis of interpretations of clinical findings, which vary among practitioners. In addition, the settings in which care is provided can vary considerably over time. For example, women with PID who would have been hospitalized in the 1980s may be treated in outpatient facilities today. Future declines in the incidence PID will hinge in part upon expansion of screening and treatment programs for chlamydia and gonorrhea as well as expansion of health promotion efforts that increase both public and provider awareness.

Syphilis Elimination: Syphilis is extremely concentrated geographically. Approximately 80% of U.S. counties have already eliminated syphilis, and 94% have a syphilis rate of ≤ 4 per 100,000. Over 50% of syphilis cases in 2001 were reported from 21 counties. Syphilis remains an important problem in the South and in some urban areas in other regions of the country.

Although provisional data from 2001 indicates continued progress, syphilis elimination efforts are challenged by increases among MSM in areas throughout the country. For example, a gradual increase in syphilis among men who have sex with men (MSM) has been reported from several U.S. cities, including Los Angeles, Seattle, Chicago, Miami, and New York City, possibly reflecting an increase in risk behavior in this population associated with increased wellness and well-being afforded by the availability of new, highly-effective antiretroviral therapy for HIV infection. From 1998 to 2001, outbreaks of early syphilis (including P&S and early latent) have been reported from these cities.

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The outbreaks in these five cities have been characterized by high rates of HIV co-infection. Although the total number of cases identified so far among MSM is relatively small, these outbreaks present a new challenge to attaining the national syphilis elimination objective of reducing the number of reported P&S syphilis cases to fewer than one thousand. Syphilis remains one of the most glaring examples of racial disparities in health, with 2001 rates among African Americans 16 times those among white Americans, down from a 64-fold differential at the beginning of the last decade. This racial disparity (16:1) is extreme compared to most other health outcomes including AIDS (9:1), infant mortality (2.5:1), and deaths attributable to heart disease (1.5:1).

Rates for Hispanics increased by 31.2% from 1997 to 2001. Communities burdened by poverty, racism, unemployment, low rates of health insurance, and inadequate access to health care are often disproportionately affected by syphilis. CDC aims to continue reducing this racial disparity in 2004.

Reduce the incidence of congenital syphilis: The lack of syphilis serologic testing and treatment during pregnancy remains the major reason that congenital syphilis persists in the U.S. Each positive test in a child is considered a medical emergency with immediate health services follow-up. The absence of testing is often related to complete lack of, or late initiation of, prenatal care. In 2001, 441 cases of congenital syphilis were reported to CDC, a rate of 11.1 cases per 100,000 live births. Now below the 2001 target of 12/100,000, this rate reflects a 59% decline in the number of cases since 1997 (1078 to 441 cases).

Tuberculosis (all):

Information on the percentage of TB patients reported in 2004 who complete TB treatment within 12 months will be available in June 2006. The last TB cases reported on December 31, 2004 will not have their 12-month treatment period completed until December 31, 2005. Then, 6-9 months are needed to tabulate, complete, verify, and report the data. This information is obtained from the national TB Surveillance System.

Information on the percentage of TB cases reported in 2004 with initial positive cultures and drug susceptibility results will be available by June 2005. This information is obtained from the national TB Surveillance System.

CDC recently revised the national reports for the data that addressed the following two measures: (1) Increase the percentage of contacts of infectious cases who are placed on treatment for latent TB infection and complete a treatment regimen; and (2) Increase the percentage of other high-risk infected persons who are placed on treatment for latent TB infection and complete a treatment regimen. For the first measure, the definition for contacts changed from contacts of "infectious cases" to "sputum smear-positive cases". The new system came on-line in CY 2000; the data for 1999 will not be representative because of the transition that occurred. The data for 2000 will not be submitted by the states until August 2002. Because the methods and definitions of reporting are substantially revised in the new system, data analysis will not yield results for these measures until after August 2003. Because of the change in definitions, program performance will appear to drop between 1998 to 1999, but the data are not comparable.

Information on the completion of treatment for latent TB infection for contacts of smear-positive cases who are started on treatment in 2004 will be available in mid-2006. Depending on the regimen used, it takes 2-9

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months to complete treatment. Therefore, some patients will not complete treatment until December 31, 2005. Approximately 6-9 months are allowed to tabulate, complete, verify, and report the data. This information is obtained from the national Aggregate Reports for TB Program Evaluation.

Information on the percentage of complete reporting of surveillance data items for TB cases reported in 2004 will be available by June 2005. This information is obtained from the national TB Surveillance System.

TB morbidity data and related information submitted via the national TB Surveillance System are entered locally or at the state level into CDC-developed software. The software contains numerous data validation checks. Data received at CDC are reviewed to confirm their integrity and evaluate completeness. Routine data quality reports are generated to assess data completeness and identify inconsistencies. These reports are shared with the reporting areas and discussed during site visits.

Data submitted via the national Aggregate Reports for TB Program Evaluation are checked for accuracy and inconsistencies. Problems are resolved by CDC staff working with state and local TB program staff. During regular visits to state, local, and territorial health departments, CDC staff review TB registers and other records and data systems and compare records for verification and accuracy. At the end of each year, data are again reviewed before data and counts are finalized and published.

Immunization

Data is obtained from a variety of sources, including the National Notifiable Disease Surveillance System (NNDSS), CDC, EPO; the National Congenital Rubella Syndrome Registry (NCRSR), CDC, NIP; the Active Bacterial Core Surveillance (ABCs), Emerging Infections Programs, CDC, NCID; and the National Health Interview Survey (NHIS), CDC, NCHS.

Public Health Improvement

REACH: Grantees will report on the development of implementation and evaluation plans, which will be reviewed by CDC staff. Site visits and data acquired by the CDC grant reporting system are also used. No data lags are expected.

The measure will be verified by the CDC grant reporting system.

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Approach to Performance Measurement

CDC and partners are concerned with a spectrum of health issues, including infectious diseases, chronic conditions, adverse reproductive outcomes, environmentally related conditions, occupationally related health events, and injuries. This array of health conditions and outcomes requires a variety of intervention strategies for populations, in addition to clinical preventive services for individuals. CDC engages in extensive dialogue with partners, communities, and the public to identify and implement intervention strategies that address the specific needs of diverse populations. Examples include the provision of prophylactic measures (e.g., vaccination, post-exposure prophylaxis), educational services (e.g., dissemination of public health messages, counseling), inspection of food establishments, and control of disease outbreaks. For these activities, the rational development of public health policy depends on public health information.

A variety of CDC data systems provide the science base for identifying health problems, designing interventions, and monitoring program performance (See Appendix D). These data systems face considerable challenges in addressing each of these three areas. For the most part, data systems that were designed to support scientific objectives are now becoming important for the monitoring of performance. Challenges in obtaining data to monitor performance under GPRA include the following:

1. As GPRA measures are refined over time, data systems to produce data with a frequency that corresponds to the periods during which performance is measured.
2. As health system changes, historical data series may not continue to produce needed data. For example, the move toward managed care may make medical information increasingly proprietary and impede access to data for research and statistical purposes. Similarly, changes in relationships among healthcare providers and laboratories may make public health surveillance based on case reports more difficult. At the same time, these changes present opportunities for new data-system partnerships.
3. Data systems will need to produce information of sufficient quality and precision to detect relatively small changes in performance indicators. This may require investments in larger sample sizes for surveys and new technologies for improving data quality. Continuing research will be required to establish the data systems and underlying evaluation approaches to assess causes (program interventions) and effects (outcomes) for performance monitoring.
4. Many national data systems are the source of GPRA measures for CDC and other health programs. These systems must be assessed and upgraded to remain current with the public health infrastructure. Resources to ensure the maintenance and strengthening of these data systems are included in the FY 2002 CDC budget request and need to be continued.
5. Because many CDC and DHHS programs are implemented at state and local levels, it will be increasingly important to obtain reliable, systematic data at these levels for monitoring of program implementation, performance, and outcomes.

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Ascertaining what information is needed and how to collect it is a complex issue. Information for action must be useful to public health programs at local, state, and national levels. CDC and partners use at least seven categories of information to understand and address disease, injury, and disability using the public health model. These categories of information include:

- Reports of health events affecting individuals;
- Vital statistics on the entire population;
- Information on the health status, risk behaviors, and experiences of populations;
- Information on potential exposures to environmental agents;
- Information on public health programs;
- Information useful to public health but obtained by organizations not directly involved in public health practice; and
- Information on the healthcare system and its impact on health.

Reports of health events: Reports of cases of diseases of public health importance form the basis for many CDC programs. The National Notifiable Disease Surveillance System (NNDSS) seeks reports on all cases of >40 conditions in the United States. To minimize the burden placed on those who report the data, CDC limits the amount of information collected for each case. NNDSS data are used to monitor disease trends, evaluate public health programs, and identify unusual occurrences of conditions that may require further epidemiologic investigation at the local level.

For some public health purposes, effective action requires additional details on each case. Supplemental data collection systems have therefore been developed for some of the diseases reported to NNDSS. These systems may be less comprehensive in terms of populations represented but provide more detailed information on characteristics of the occurrence of disease. For example, cases of hepatitis are reported weekly to NNDSS for publication in the *Morbidity and Mortality Weekly Report (MMWR)*. In addition, the Viral Hepatitis Surveillance Project collects data on risk factors for different types of viral hepatitis in selected geographic areas. These data have been used to document the importance of behaviors associated with sexual activity and drug use as risk factors for transmitting hepatitis B virus and to target education and vaccination programs.

Control of some conditions requires more detailed information than can be obtained feasibly from a large group of clinicians or institutions. Networks of selected healthcare providers have therefore been organized to meet these targeted information needs. For example, CDC's Sentinel Event Notification System for Occupational Risks (SENSOR) targets groups of healthcare providers as a component of a comprehensive approach for obtaining data on which to base efforts to prevent workplace-related morbidity. The National Nosocomial Infections Surveillance System (NNIS) receives reports from a selected group of hospitals on the incidence and characteristics of hospital-acquired infections. Data from this system have been instrumental in alerting health authorities to the emergence of antibiotic-resistant strains of bacteria, which in turn has led to the development of recommendations for the appropriate use of antibiotics.

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Vital statistics: Vital records (e.g., births, deaths) are the primary source of some of the most fundamental public health information. Data on teen births, access to prenatal care, maternal risk factors, infant mortality, causes of death, and life expectancy are among the staples of public health information provided by vital statistics. Vital statistics are often the most complete and continuous information available to public health officials at the national, state, and local levels; the timely availability of these data is critically important.

In the United States, the legal authority for vital registration rests with the states and territories. CDC's National Center for Health Statistics (NCHS) produces national vital statistics by collecting data from the vital records of the states. NCHS works with the states to ensure a uniform national data base through the promotion of standard data collection forms and data preparation and processing procedures and also provides partial financial support for state systems.

Health status, risk factors, and experiences of populations: Since the determinants of many health problems are behavioral, environmental, or genetic, health agencies need information that is not readily available from medical records on the prevalence of various types of behavior and on access to care. Thus, regularly conducted surveys of the general population are needed for public health. These surveys range from large-scale assessments of the general population to assessments targeted at high-risk (i.e., particularly vulnerable) populations. This need is particularly acute at the state and local levels. Surveys provide information on: 1) baseline health status, 2) morbidity, 3) prevalence of behavioral risk factors, 4) use of healthcare services and identification of underserved populations, and 5) potential for exposure to toxic agents. Information generated from the surveys is used in developing prevention and control programs and in ensuring adequate delivery of health services.

Potential exposure to environmental agents: Information on exposures to environmental agents can be used in evaluating the risks to health from noninfectious diseases, injuries, and certain infectious diseases. For example, measurement of airborne particulates is useful in assessing risks related to pulmonary disorders such as asthma and lung cancer. Information on vectors that may carry agents of infectious disease is important in evaluating the risk for acquiring such infections.

Program information: Data needed to operate public health programs include the number of clients served and the costs of services rendered. These data are useful to public health officials in assessing the effectiveness of public health programs, comparing programs, documenting the need for continuing a particular program, and maintaining accountability for tax dollars spent.

Information from other organizations: Data useful for public health are currently or potentially available from organizations whose functions may not be related to those of CDC and state and local health departments. Data from the Bureau of the Census, for example, are needed for both the reliable computation of rates and the proper adjustment of rates for comparison over time or in different geographic areas. The Environmental Protection Agency (EPA) compiles environmental air-monitoring data to assess compliance with standards for air pollutants established by the Clean Air Act. Data collected through this system are used by public health officials for hazard alerts when pollutants exceed federal standards and in studies of the effects of air pollutants on morbidity associated with respiratory diseases. The Occupational Safety and Health Administration (OSHA) and the Bureau of Labor Statistics compile data on the occurrence

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of work-related injuries and illnesses and exposure to hazards in the workplace, which can be used for surveillance and research. The Department of Transportation operates the Fatal Accident Reporting System, used in public health to assess risk factors for motor-vehicle-related injuries and deaths. Crime statistics gathered by the Federal Bureau of Investigation (FBI) assist in evaluating the public health impact of intentional injuries, and the Consumer Product Safety Commission collects data on injuries related to consumer products.

Information on the healthcare system: Information is also needed on the healthcare system and the health impact resulting from changes in the system. CDC provides a great deal of information to monitor the capacity of the healthcare system, utilization of the system, and access to health insurance and services by the American people. These data include: inventories of healthcare providers; patterns of utilization of health services such as hospitalization rates and uptake of new technologies; and access to health care and barriers (both financial and non-financial) to access.

Linkages with Budget, Cost Accounting, Information Technology Planning, Capital Planning, and Program Evaluation

Clinger-Cohen Act

CDC has implemented the requirements under the Clinger-Cohen Act of 1996 (CCA) for information technology (IT) capital investment planning, monitoring, and performance measurement. The Information Technology Investment Review Board (ITIRB) process has been established and was released CDC-wide on January 5, 1999, via the CDC Intranet. CCA compliance became a component of the CDC budget planning process for the FY 2001 budget. Major IT investments associated with budget initiatives required the development of a Capital Asset Plan and Business Case (Exhibit 300) as part of the submission.

Also in compliance with CCA, CDC has developed several components of the agency's information technology architecture, such as certain health data standards, networking and telecommunications architecture, information security, and the majority of the agency's administrative procedures. More extensive work on other core business processes, information flows, process and data models is ongoing.

In addition to efforts in the implementation of CCA, CDC has a well-integrated GPRA and IRM Strategic Plan that aligns IT products and services with CDC's ever-changing mission needs and directions. The IRM strategic goals, strategies and performance measures support the mission, mission goals, and CDC's GPRA performance plan.

Linkages with the President's Management Agenda

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CDC has been actively pursuing goals and improvements related to the President's Management Agenda (PMA) for some time. For example, from 1997 to 2001, CDC decreased its proportion of administrative positions by 6 percent. CDC has historically focused on keeping the agency market-based and efficient by having over 3,000 service contractor staff engaged to conduct commercially-oriented responsibilities. In addition, in 2000, CDC established its Fiscal Management Excellence Initiative, which has further enhanced its efforts to improve fiscal performance. In FY 2002, CDC had a less than one percent variance between allotted agency FTE levels and actual FTE usage, thus, effectively integrating strategic workforce planning with budget and program execution. CDC is also organized to effectively address and lead PMA issues in several ways. For example, CDC has established an Executive Steering Committee to help concentrate management attention on the PMA, and has appointed a full-time, executive leader to coordinate activities and articulate the interdependence among the initiatives.

CDC has received its FY 2002 PMA, "Progress", Scorecard results. HHS provided CDC three "Green" lights and two "Yellow" lights. The "Green" lights included the Competitive Sourcing, Improved Financial Management, and Expanded E-Government Initiatives. The "Yellow" lights included Strategic Management of Human Capital and Enhanced Budget and Performance Integration Initiatives. These scores reflect the continuing leadership and hard work that CDC management and staff are focusing on the PMA.

Strategic Management of Human Capital

Strategic Management of Human Capital is a priority for CDC. The agency received a "Yellow" Scorecard on this Initiative, indicating achievement of some, but not all, goals. CDC has established a number of specific and measurable goals to address Strategic Management of Human Capital issues. For example, by 2004, CDC's supervisory ratio will increase to 1:9. Between July 2001 and January 2003, CDC's supervisory ratio increased by 57 percent, as an indication of the continuing success in flattening and delayering the agency. Another PMA Human Capital goal is to increase the span of control/organizational size to 12 FTE's in each Branch by 2004. CDC's Human Resources Management Office (HRMO) continues to work with each CIO to help assure that Human Capital goals are met.

CDC is continuing to work to further address Workforce Restructuring issues. For example, as of January 2003, CDC had already abolished 85 percent of the 125 administrative and management positions required to be abolished by September 2003. In addition, CDC continues to search for ways to further delayer the agency. As part of this effort, CDC has recently abolished a net of about 40 organizational units.

Increased Competitive Sourcing

CDC received a "Green" Scorecard result from HHS, documenting that all goals for the period had been achieved. CDC has developed competitive sourcing plans for FY 2002, 2003, and 2004, and is carrying out these plans. The plans set forth the strategy to conduct studies or directly convert 5 percent of the agency's commercial-type positions in FY 2002, 10 percent in 2003, and 10 percent in 2004. CDC fully achieved the FY 2002 goal. In 2003, CDC is conducting public-private competitions and/or direct conversions for not less than the additional 10 percent of the CDC FTEs listed in its FAIR Act Inventory as performing commercial work. CDC has also delivered its FAIR Act Inventory on time and in full conformance with HHS' guidance. Finally, CDC has acquired outside contractor support to provide assistance for these continuing competitions.

Improved Financial Management

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CDC received a “Green” Scorecard result from HHS on this Initiative, documenting that CDC continues to make great strides in this area. For the past five years, CDC has received an unqualified opinion on the financial statements performed by independent auditors. A new HHS-wide financial management system, the Unified Financial Management System (UFMS), will be implemented to replace five legacy accounting systems currently used across CDC. The current accounting system is based on software that is 16 years old and requires substantial, labor-intensive effort. CDC and HHS kicked off the implementation of the CDC segment of the UFMS development in October 2002. CDC also employs a comprehensive method to allocate indirect costs that fund internal operations. This method, developed with the assistance of Ernst and Young, LLP, correlates work performed and centrally mandated services, thus, directly linking users of services with the actual cost of performing these services. CDC also has been graduating staff from its Financial Management Certificate Program and currently has over 200 staff enrolled. CDC has continued its success in minimizing erroneous payments. In FY 2002, the agency issued 99.96 percent accurate payments. In addition, CDC leads in the area of prompt payment with a 97 percent compliance rate.

Expanded E-Government

CDC continues to be a leader in E-Government initiatives, as reflected by the “Green” Scorecard provided by HHS. Some CDC leadership efforts include:

- Actively engaging in seven government-wide E-Gov initiatives, such as e-Vitals, consolidated health informatics (CHI), e-Travel, e-Grants, and Geospacial Information One Stop, with an initial 16 CDC programs, representing \$4.4 billion.
- Contributing to HHS initiatives, such as leading the HHS large agency IT infrastructure consolidation initiative, serving as Program Manager for the Security Team, and engaging in the HHS Enterprise IT Strategic Plan, UFMS, Enterprise Human Resources and Payroll, and HHS enterprise information security.
- Progressing towards compliance with the Government Paperwork Elimination Act (GPEA) by the October 2003 deadline by making data collections and disseminations enabled electronically.
- On-going enhancement of the CDC web presence as the authoritative and trusted source of public health information for healthcare providers, public health officials, the media, and the public. Over 5 million different visitors per month make CDC’s website one of the most frequently visited government websites. The events of 9/11 and the anthrax infections drew over 9 million visitors to the CDC website in October 2001 alone.

Enhanced Budget and Performance Integration

CDC continues to work diligently on improving budget and performance integration. This work has spanned the organization, and has included staff from planning and budget offices, the procurement and grants office, and virtually every program across CDC. Accomplishments this year include:

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Annual Plan/Report Submission

CDC's annual performance plan and report was substantially revised in the spring and early summer. Submitted on June 7, the plan complied with the Department's Detailed Instructions. Significant changes and improvements to the plan included:

- Inclusion of an executive summary that reinforces the link between the performance plan and the budget request while highlighting past, present, and future performance;
- Creation of a "performance road map" that clearly shows the relationship between CDC major budget activities and performance goals undergirding them;
- Provision of a more meaningful referencing system wherein performance measures are related to the budget request, Healthy People 2010, HHS Strategic Plan Goals, and the President's Management Agenda; and
- Improvement in the quality and comprehensiveness of appendices. These improvements included a more coherent discussion of our partnership and coordination activities, as well as enhancements to our data verification and validation section of the plan.

Program Outcomes

CDC's Fiscal Year 2003 Performance Plan contained 228 performance measures, 57 (25%) of which were outcome measures. We made significant strides in reducing our over-all number of measures while increasing outcomes. Our FY 2004 plan submitted to HHS in June contained 188 performance measures, 61 (32%) of which were outcome measures. This submission reflects yet a further refinement of measures, containing only 100 measures, 39 (39%) of which are outcome measures.

Program Effectiveness

OMB identified five CDC programs for the Program Assessments. These programs included immunization, breast and cervical cancer, diabetes, domestic HIV/AIDS, and Health Alert Network. However, prior to OMB's identification of the programs, CDC formed a cross-agency working group to discuss ways in which to effectively capture program performance data. This working group served as a springboard for the five programs who were ultimately selected to participate in the assessment activities, and OMB's assessment tool (the PART) contained many of the components that the working group had previously discussed.

Thorough reviews of the five programs were carried out at CDC. Smaller, program-specific working groups were formed to develop responses to the PARTs. Consistency across the workgroups was provided by staff in CDC's Office of Program Planning and Evaluation. In addition, the Financial Management Office and Procurement and Grants Office provided critical input into questions that involved financial and procurement policies and procedures.

In June 2002, the five assessment tools and supporting documentation were sent to HHS on time and with complete responses. In the months that followed, HHS and CDC conducted conference calls with OMB to discuss the assessment tools, and CDC provided an array of information requested of us by OMB to help inform their assessments of our five programs. Each of the five programs has successfully completed the assessment process and received its final rating in December 2002. We are currently working on improvements identified as a result of the PART process.

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Public Health Grant Initiative (OMB Management Agreement)

One of the key components of the OMB/DHHS management agreement involved creation of a pilot program at CDC to streamline several grants programs. Asthma, diabetes, and obesity grant programs were selected as the candidate programs. Multiple offices and programs across CDC worked on this cross-cutting activity with DHHS. CDC offices included: planning offices in the Office of the Director, the National Center for Chronic Disease Prevention and Health Promotion, and the National Center for Environmental Health, as well as the CDC Procurement and Grants Office. Programs involved included two in the National Center for Chronic Disease Prevention and Health Promotion (diabetes and obesity), and the asthma program in the National Center for Environmental Health.

This project is on-going; a brief time line and list of deliverables depicting the process are provided below:

- 3/25/02: Initial Envision meeting between DHHS and CDC to describe the project.
- 4/3/02: Project time line developed.
- 4/19/02: CDC submits initial information to DHHS. This information includes (by program): program descriptions, list of administrative burdens, logic models, and program outcomes.
- 4/30/02: DHHS meets with OMB.
- 5/1/02: Conference call between DHHS and CDC to debrief on OMB meeting.
- 5/22/02: CDC receives Excel spreadsheet from DHHS containing recommended items to be addressed by each program.
- 6/11/02: CDC submits completed spreadsheets to DHHS.
- 8/15/02: CDC internal workgroup reconvenes to discuss next steps.
- 8/29/02: Teleconference between OMB, DHHS, and OMB held.
- 9/9/02: CDC submits revised pilot project proposal to DHHS.

Over the course of this project, CDC has provided a variety of information including:

1. A list of administrative burdens associated with each grant program;
2. Draft outcome measures for each of the grant programs;
3. Reduction in the over-all number of grant announcements within each programmatic area;
4. Streamlined processes for the application review process;
5. Streamlined progress reporting processes; and
6. Projections of savings in cost, burden hours, and progress reporting for CDC and the states once proposed streamlined processes are implemented.

Based upon OMB's response to the materials submitted in June, CDC staff who worked on this project reconvened in August, 2002. OMB's comments were reviewed and the team identified key issues regarding this project. A revised proposal was developed, vetted through HHS policy and procurement offices, and submitted to OMB on September 26, 2002.

Appendix F Change Chart

Centers for Disease Control and Prevention

FY 2002/03 Change Chart for Goals and Performance Measures

Program Activity	Goal	FY 2002/03 Original Performance Measure	Revision and Explanation
Birth Defects/Dev. Disabilities and Health	Improve the health status of Americans with disabilities. Originally worded: Monitor, characterize, and improve the health status of Americans with disabilities		Revised goal to be more outcome-oriented
	Improve the health and quality of life of Americans with disabilities	Reduce the number of children with birth defects due to prenatal alcohol exposure by increasing the percentage of women who report abstinence of any alcohol consumption during pregnancy.	Revised measure
		Improve the quality, comprehensiveness, and usefulness of data derived from the National Birth Defects Prevention Network.	Revised measure
		Increase the number of states collecting community-based data on autism and other developmental disabilities.	Revised measure
	Prevent birth defects and developmental disabilities	Reduce the number of children with birth defects due to prenatal alcohol exposure by increasing the percentage of women who report abstinence of any alcohol consumption during pregnancy.	Simplified the language. Now reads: Reduce the percentage of women who report any alcohol consumption during pregnancy.
Birth Defects/ Disabilities continued	Prevent birth defects and developmental disabilities	Improve the quality, comprehensiveness, and usefulness of data derived from the National Birth Defects Prevention Network.	Language changed for clarity. Now reads: Increase the number of American births covered by birth defects monitoring programs (data used to plan services to children, evaluate prevention, and plan future prevention strategies).

Appendix F Change Chart

Program Activity	Goal	FY 2002/03 Original Performance Measure	Revision and Explanation
Birth Defects/ Disabilities continued	Improve the data on the prevalence of birth defects and developmental disabilities.	Increase the number of states participating in the National Birth Defects Prevention Network.	Measure deleted from 2003 plan due to required reduction in the number of measures.
	Monitor, characterize, and improve the health status of Americans with disabilities.	Increase the number of states biennially utilizing the state Behavioral Risk Surveillance System to monitor the health status of people with disabilities.	Measure deleted from 2003 plan due to required reduction in the number of measures.
Chronic Disease/Health Promotion Breast and Cervical	Increase early detection of breast and cervical cancer by building nationwide programs in breast and cervical cancer prevention, especially among high-risk , under served women.	Excluding breast cancers diagnosed on an initial screen in the NBCCEDP, diagnose at least 70% of women aged 40 and older at the localized stage.* (*first mammogram provided through CDC's NBCCEDP.)	Measure will be eliminated effective FY 03 due to concerns about data quality.
	Increase early detection of breast and cervical cancer by building nationwide programs in breast and cervical cancer prevention, especially among high-risk , under served women.	Excluding invasive cervical cancers diagnosed on an initial screen in the NBCCEDP, lower the age-adjusted rate of invasive cervical cancer in women aged 20 and older to not more that 22 per 100,000 Pap tests provided.* (*first Pap test provided through CDC's NBCCEDP).	Revised performance measure. Established 04 targets.
	Expand community-based breast and cervical cancer screening and diagnostic services to low income, medically underserved women. For women diagnosed with cancer or pre-cancer, assure access to treatment services.	Maintain the percentage of newly enrolled women who have not received a Pap test within the past five years.	New measure - FY 04.

Appendix F Change Chart

Program Activity	Goal	FY 2002/03 Original Performance Measure	Revision and Explanation
Chronic Disease/Health Promotion continued	Expand community-based breast and cervical cancer screening and diagnostic services to low income, medically underserved women. For women diagnosed with cancer or pre-cancer, assure access to treatment services	Increase the number of women screened. Breast: mammogram or CBE Cervical: Pap Smear	New measure - FY 04.
	Expand community-based breast and cervical cancer screening and diagnostic services to low income, medically underserved women. For women diagnosed with cancer or pre-cancer, assure access to treatment services	Increase the percentage of women with abnormal results* who receive a final diagnosis within 60 days of screening. *Breast - abnormal mammogram (suspicious of abnormality, highly suggestive of malignancy, or assessment incomplete) and/or abnormal CBE *Cervical - abnormal Pap includes high grade SIL, squamous cancer, or abnormal glandular cells	New measure - FY 04.
	Expand community-based breast and cervical cancer screening and diagnostic services to low income, medically underserved women. For women diagnosed with cancer or pre-cancer, assure access to treatment services	Increase the percentage of women with cancer who start treatment within 60 days of diagnosis.	New measure - FY 04.
	Expand community-based breast and cervical cancer screening and diagnostic services to low income, medically underserved women. For women diagnosed with cancer or pre-cancer, assure access to treatment services	<u>Cervical</u> : Increase the percentage of women with precancerous lesions* who start treatment within 90 days of diagnosis *includes CIN II, CIN III, and CIS	New measure - FY 04.

Appendix F Change Chart

Program Activity	Goal	FY 2002/03 Original Performance Measure	Revision and Explanation
Chronic Disease/Health Promotion continued Community Based Prevention Research	Support prevention research to develop sustainable and transferable community-based behavioral interventions.	Ensure that PRCs work toward closing the gap between research findings and public health practices.	Process measure
	Support prevention research to develop sustainable and transferable community-based behavioral interventions.	Ensure that at least one PRC in each DHHS region established research priorities and develops interventions in collaboration with a constituent community.	Process measure - historically achieved target.
Heart Disease	Increase the capacity of state cardiovascular health programs to address prevention of cardiovascular disease at the community level	Increase the number of states with five of the seven core heart disease and stroke prevention capacities.	Measure will be deleted effective FY 03. CDC has historically met the target for this measure. A new measure has been developed.
	Reduce death and disability due to heart disease and stroke and eliminate disparities.	Reduce the proportion of heart disease and stroke deaths that occur before transport to emergency health services.	New measure - FY 04.
	Reduce death and disability due to heart disease and stroke and eliminate disparities.	Reduce the prevalence of uncontrolled high blood pressure (BP \geq 140/90), among patients with hypertension, especially among populations at high risk, in states that collaborate with community health centers.	New measure - FY 04.
Diabetes	Increase the capacity of state based diabetes control programs to address the prevention of diabetes and its complications at the community level.	Increase the percentage of diabetes control programs that adopt, promote, and implement guidelines for improving the quality of care for persons with diabetes.	CDC has historically met target. Measure will be deleted effective FY 03. CDC is eliminating this measure based on the mandate to reduce the total number of measures in the performance plan.
Program Activity	Goal	FY 2002/03 Original Performance Measure	Revision and Explanation

Appendix F Change Chart

Chronic Disease/Health Promotion continued	Increase the capacity of state based diabetes control programs to address the prevention of diabetes and its complications at the community level.	Conduct studies on translating research findings into clinical and public health practice, and publish results in peer-reviewed journals.	CDC has historically met target. Measure will be deleted effective FY 03. CDC is eliminating this measure based on the mandate to reduce the total number of measures in the performance plan.
	Increase the capacity of state diabetes control programs to address the prevention of diabetes and its complications at the community level.	For states receiving CDC funding for diabetes prevention and control programs (DPCPs), increase the percentage of persons with diabetes who receive annual eye and foot exams. *Refers to basic implementation states (Formerly comprehensive) only.	New measure - FY 04.
	Increase the capacity of state diabetes control programs to address the prevention of diabetes and its complications at the community level.	For states receiving CDC funding for diabetes prevention and control programs (DPCPs), increase the percentage of persons with diabetes who receive at least two A1c measures per year.	New measure - FY 04.
	Increase the capacity of state diabetes control programs to address the prevention of diabetes and its complications at the community level	By 2010, decrease by 20% the number of people with pre-diabetes who advance to diabetes among states with pre-diabetes programs. *New initiative	New measure - FY 04.
Diabetes	Increase the capacity of state based diabetes control programs to address the prevention of diabetes and its complications at the community level.	Increase the percentage of DCPs with one capacity in all key areas (e.g. surveillance, partnerships, communication networks, assessment of quality care, public awareness.)	CDC has historically met target. Measure will be deleted effective FY 03. CDC is eliminating this measure based on the mandate to reduce the total number of measures in the performance plan.
Program Activity	Goal	FY 2002/03 Original Performance Measure	Revision and Explanation

Appendix F Change Chart

Chronic Disease/Health Promotion continued	Increase the capacity of state diabetes control programs to address the prevention of diabetes and its complications at the community level	Increase the number of DPCPs that promote health system approaches to identifying persons who are at high risk for developing diabetes (e.g. obese and/or impaired glucose metabolism). *New initiative	New measure - FY 04.
HIV Prevention among School-aged Youth	Reduce cigarette smoking among youth	Reduce the percentage of youth (grades 9-12) who smoke.	Revised target.
	Decrease levels of obesity or reduce the rate of growth of obesity in communities reached through nutrition and physical activity interventions.	Increase the number nutrition and physical activity interventions that are implemented and evaluated in funded states.	New measure - FY 04.
Arthritis	Increase the capacity of state arthritis programs to address the prevention of arthritis and its complications at the community level.	Enhance state based arthritis surveillance by increasing the number of states using BRFSS modules on arthritis and quality of life.	CDC has historically met target. Measure will be deleted effective FY 03. CDC is eliminating this measure based on the mandate to reduce the total number of measures in the performance plan.
	Increase the capacity of state arthritis programs to address the prevention of arthritis and its complications at the community level.	Increase the number of states addressing arthritis at the core level.	Process measure - historically achieved target
	Support prevention research to develop sustainable and transferrable community-based behavioral interventions.	Ensure that at least one PRC in each DHHS region establishes research priorities and develops interventions in collaboration with a constituent community.	CDC has historically met target. Measure will be deleted effective FY 03. CDC is eliminating this measure based on the mandate to reduce the total number of measures in the performance plan.
Program Activity	Goal	FY 2002/03 Original Performance Measure	Revision and Explanation

Appendix F Change Chart

Chronic Disease/Health Promotion continued	Support prevention research to develop sustainable and transferrable community-based behavioral interventions.	Ensure that PRCs work toward closing the gap between research findings and public health practices.	CDC has historically met target. Measure will be deleted effective FY 03. CDC is eliminating this measure based on the mandate to reduce the total number of measures in the performance plan.
Cancer Registries	Improve the quality of state based cancer registries	Increase the percentage of states funded by CDC's NPCR that report at least 95% of unduplicated, expected cases of reportable cancer in state residents in a diagnosis year.	Measure will be deleted effective FY 03. CDC is eliminating this measure based on the mandate to reduce the total number of measures in the performance plan.
Managing Risk Behaviors - BRFSS	Help states monitor the prevalence of major behavioral risks associated with premature morbidity and mortality in adults to improve the planning, implementation, and evaluation of health promotion and disease prevention programs.	Increase the number of states participating in the BRFSS that complete 4,000 telephone interviews per year.	Measure will be deleted effective FY 2003. CDC has historically achieved the targets.
Environmental Health Newborn Quality Assurance	Ensure the quality of lab technologies to quickly and accurately detect inherited disorders in newborns	Increase the number of disorders covered by the Newborn Screening Quality Assurance Program (this is a measure that has been deleted from the June 02 submission).	NCEH has met the target for the past 2 fiscal years and there are no plans to change the target, e.g. increase the number of disorders which are covered by the program.
Asthma	Improve state and local public health capacity to control asthma	States will have implemented core asthma programs (this is a measure that has been deleted from the June 02 submission)	This is not an outcome measure. The overall purpose of the state grants is to reduce asthma morbidity. This goal is more accurately measured in the remaining asthma measure regarding asthma hospitalizations.
Program Activity	Goal	FY 2002/03 Original Performance Measure	Revision and Explanation

Appendix F Change Chart

<p>Environmental Health continued</p> <p>Childhood Lead Poisoning</p>	<p>Reduce the burden of lead poisoning in children</p>	<p>Increase the percentage of CDC-supported states with systems to determine the number of Medicaid-enrolled children who are screened for lead poisoning (this is a measure that has been deleted from the June 02 submission)</p>	<p>This measure does not accurately convey the actual number of Medicaid children screened for lead poisoning. The first measure regarding reducing the number of children with elevated blood lead levels is the overarching goal of the program and the number of Medicaid children screened is subsumed in that measure.</p>
<p>Genomics</p>	<p>Help states use genetic information in their public health programs</p>	<p>Increase the number of states receiving technical assistance from CDC to integrate genetics into public health (this is a measure that has been deleted from the June 02 submission)</p>	<p>This is a process measure. The second measure in this section more accurately captures the intent of the program.</p>
<p>Epidemic Services and Response</p>	<p>Maximize the distribution and use of scientific information and prevention messages through modern communication technology.</p>	<p>Based on established criteria continue to publish the Morbidity and Mortality Weekly Reports (MMWR) series of publications including Reports and Recommendations, Surveillance Summaries, and the Annual Summary to communicate major public health events to the media, public policy makers and health professionals through multiple media channels -- print, television, radio, interactive World Wide Web.</p>	<p>Achieved - deleting measure</p>
		<p>The MMWR will refine communication efforts through a Center-wide communications plan to provide a framework for current activities and maximize communicating public health messages through print and the World Wide Web.</p>	<p>Achieved - deleting measure</p>
<p>Program Activity</p>	<p>Goal</p>	<p>FY 2002/03 Original Performance Measure</p>	<p>Revision and Explanation</p>

Appendix F Change Chart

Epidemic Services and Response continued	Efficiently respond to the needs of our public health partners through the provision of epidemiologic assistance	Based upon established criteria for participation, Epidemic Intelligence Service (EIS) officers will respond to at least 95% of the requests for epidemic assistance from domestic and international partners	Achieved - deleting measure
	Build expertise within CIOs to conduct prevention effectiveness studies of public health interventions.	Increase the number of professional prevention effectiveness staff and fellows.	Consolidated & deleting measure - after 2002
		Increase the number of staff in CIOs who can use prevention effectiveness methods.	Consolidated & deleting measure - after 2002
	As a long-term objective, CDC will implement accessible training programs to provide an effective workforce for staffing state and local health departments, laboratories, and ministries of health in developing countries.	Provide for effective workforce for staffing state and local health departments and in other public health related organizations.	Consolidated & deleting after 2002
		By FY 2002, implement the plan to address needed changes in EIS training methodologies identified in the evaluation study.	Achieved - deleting measure
		Number of courses to train state and local public health professionals in epidemiology, surveillance, informatics, prevention effectiveness, and management through a program modeled after the EIS program.	New measure
		Number of EIS officers assigned to state or municipal health departments.	New measure
Program Activity	Goal	FY 2002/03 Original Performance Measure	Revision and Explanation

Appendix F Change Chart

HIV/AIDS Prevention	Increase the proportion of HIV-infected people who know they are infected.	Increase the percentage of HIV-positive tests for which persons return for results.	Revised for accuracy: Increase the percentage of HIV-positive tests from CDC funded test sites with post-test counseling sessions reported
	Strengthen the capacity nationwide to monitor the epidemic, develop and implement effective HIV prevention interventions and evaluate prevention programs.	Increase the number of states that conduct HIV case reporting.	Revised for accuracy: Increase the number of states and District of Columbia that conduct HIV case reporting in adults and adolescents.
	All	All	Goals changed to better align with HIV Prevention Strategic Plan Through 2005.
Tuberculosis	Eliminate tuberculosis in the United States	Target revision: Increase the percentage of contacts of infectious (AFB smear-positive) cases who are placed on treatment for latent TB infection and complete a treatment regimen.	Targets for 2000 and later years have been adjusted to reflect changes in data collection methods.
Immunization	Improve Vaccine Safety Surveillance	Expand the network of CDC and CDC-funded staff, virologists, epidemiologists, technical and scientific officers on long-term assignments in WHO country and regional offices.	The following performance measures were replaced or omitted in favor of more outcome oriented measures. CDC will continue to report on these measures until 2002, as they were previously included in the FY 2002 Performance Plan.
		Expand a special program to prepare a cadre of trained public health professionals throughout CDC to complete short-term assignments with WHO.	Deleting measure
Program Activity	Goal	FY 2002/03 Original Performance Measure	Revision and Explanation

Appendix F Change Chart

Infectious Diseases Control Continued		Use new data mining techniques to increase the number of detected true and false signals of adverse events associated with vaccination.	Deleting measure
		Expand the Vaccine Safety Datalink (VSD) sites to increase the number of persons under active surveillance for vaccine safety.	Deleting measure
		Improve the ability of health care providers to report vaccine adverse events, including those associated with influenza vaccine, by pilot testing electronic reporting to VAERS in managed care organizations.	Deleting measure
Immunization	Improve vaccine safety surveillance.	Increase the number of persons under active surveillance for vaccine safety via large linked databases to 13 million people by 2010.	Revised for more outcome-oriented measure.
	Strengthen epidemiologic and laboratory capacity to recognize, respond to, and monitor infectious diseases	Increase on-site technical support and assistance to the 57 state-based prevention programs funded through the ELC cooperative agreement by increasing percentage of programs visited within the budget year..	Revised measure
	Apply scientific findings to prevent and control infectious diseases	Expand surveillance for unusual HIV variants.	Measure moved from HIV section to the Infectious Diseases Control section
Epidemiology and Laboratory Capacity	#1: Strengthen epidemiologic and laboratory capacity to recognize, respond to, and monitor infectious diseases.	#1: Increase the number of EID microbiology fellows trained for employment in public health laboratories.	Process-oriented. Another measure is being developed to better reflect outcomes from increasing EID fellows.
Program Activity	Goal	FY 2002/03 Original Performance Measure	Revision and Explanation

Appendix F Change Chart

Infectious Diseases Control Continued Priority Disease Problems	Protect Americans from priority infectious diseases.	#2: Increase the number of states and/or local health departments that integrate viral hepatitis preventing into STD and HIV treatment programs.	Process-oriented
		#3: Provide support to 20 health departments to assess the effectiveness of integration of HCV counseling, testing, and referral programs.	
		Establish sentinel surveillance systems for chronic HCV in 10 states to monitor trends in incidence, risk factors for infection and outcomes of disease.	
	Influenza	#1. Establish sentinel surveillance sites to monitor influenza viruses (1 site/250,000 population) to enhance early detection of viruses with pandemic potential domestically.	Combined with #2 below to reduce measurements.
		#2 Provide support to build capacity for influenza surveillance wits and networks internationally to enhance early detection of viruses with pandemic potential and improve vaccine decision-making.	Combined with #1 under influenza to reduce # of measurements.
	Foodborne Illnesses	#1. Detect and investigate large or unusual outbreaks of diarrheal and or foodborne illness.	Achieved targets three consecutive years. Goal met.
		#2. Increase the proportion of foodborne outbreaks in which the causative food is identified.	Exceeded measurement for three years. Goal met/ Measurement dropped.
Program Activity	Goal	FY 2002/03 Original Performance Measure	Revision and Explanation

Appendix F Change Chart

Infectious Diseases Control Continued Antimicrobial Resistance	Reduce the spread of antimicrobial resistance	Provide support to health department s and hospitals for surveillance, prevention, and control of antimicrobial resistance	Met target two consecutive years./Goal met.
		Establish a surveillance system to collect data on antimalarial drug resistance in African countries.	Met target two consecutive years./Goal met.
Medical Errors and Healthcare-associated infections	#1. Protect Americans from death and serious harm caused by medical errors and preventable complications of healthcare.	1. Reduce the rate of central line-associated bloodstream infections in adult ICU patients to 3.80, as measured through the NNIS system.	Deleting measure. Measurement has been achieved or exceeded.
		Fund demonstration programs to develop and evaluate new strategies to measure and prevent healthcare associated infections.	Goal was not outcome oriented and removed to meet required decrease in number of measurements in performance plan. Baseline established, goals never reported.
Public and Provider Education	#1 Apply scientific findings to prevent and control infectious diseases.	#2. Establish 10 surveillance networks to monitor antimicrobial resistance, threats from transfusion of blood/blood products, and infectious diseases in travelers and immuno-suppressed and under served populations.	Achieved or exceeded three consecutive years. Goal was not outcome oriented and removed to meet required decrease in number of measurements in performance plan.
		#4. Increase participating of 134 hemophilia treatment centers in the Universal Data Collection system.	Achieve or exceeded three consecutive years./Goal met.
Injury Prevention and Control	Reduce the incidence of youth violence	In a CDC-funded youth violence project, reduce the number of students reporting incidents of fighting.	Measure achieved
		Develop best practice protocols for implementation and evaluation of youth violence prevention programs.	Measure achieved
Program Activity	Goal	FY 2002/03 Original Performance Measure	Revision and Explanation

Appendix F Change Chart

Injury Prevention and Control Continued		Increase the number of regional best practices workshops, and disseminate workshop results.	Measure achieved
	Reduce violence against women	Establish a biennial survey of the incidence and prevalence of violence against women.	Measure achieved
		Establish demonstration projects to address prevention of violence against women.	Revised measure to be more outcome-oriented.
	Reduce violence against women (continued)	Establish a research program to address understudied aspects of violence against women (e.g., assess factors of perpetration of IPV that would inform development of interventions and treatment)	Revised measure to be more outcome-oriented.
		Evaluate the effectiveness of communities with coordinated community responses.	Measure achieved
		Establish at least one surveillance system for collecting intimate partner violence data representative of an entire state	Measure achieved
	Improve the uniformity, quality, and accessibility of emergency department (ED) data for public health surveillance in several States, ultimately developing the capacity to improve data in all States through development of guidelines, recommendations, or technical assistance. Reduce the number and severity of head injuries in CDC funded projects by increasing bicycle helmet use.	Reduce the number of bicycle-related emergency department visits by 5% per year from 123,475 in 1995.	Funding for this program shifted to other injury program priorities.
Program Activity	Goal	FY 2002/03 Original Performance Measure	Revision and Explanation

Appendix F Change Chart

Injury Prevention and Control Continued		Increase the use of bicycle helmets by child and teen bicyclists in CDC-funded project areas.	Partially Achieved--funding ended in FY 00
	Improve the timeliness and quality of data used to determine the medical and social impact of traumatic brain injury.	Develop a uniform reporting system for TBI; determine incidence and prevalence; report on uses of state surveillance and follow-up registry data; disseminate information on TBI trends	Reworded for FY03 plan to say "Increase the number of states receiving CDC funding for surveillance and to identify and track injuries."
		Implement CDC guidelines for design and use of TBI registries in 2 states by 2004; report outcomes associated with TBI.	Findings disseminated and measure achieved
	Reduce the incidence of residential fire-related injuries and deaths by increasing functional smoke alarms on every habitable floor	In CDC-funded projects within 14 states (our previous round of state projects), increase the proportion of homes with at least one smoke detector on each habitable floor.	Exceeded
		In CDC-funded projects within the 13 states, increase the number of homes with at least one smoke alarm on each habitable floor.	Achieved
		Publish recommendations for conducting and evaluating smoke alarm promotion programs.	Revised measure to be more outcome-oriented.
	Increase external input on the research priorities, policies, and procedures related to the extramural research supported by CDC	Increase efficiency and effectiveness of research investments by employing competitive peer-review processes.	Revised measure to be more outcome-oriented.
	Educate the capacity of states to implement effective rape prevention and education programs	Develop case definitions for sexual assault.	Revised measure to be more outcome-oriented.
		Conduct state training programs	Revised measure to be more outcome-oriented.
Program Activity	Goal	FY 2002/03 Original Performance Measure	Revision and Explanation

Appendix F Change Chart

Injury Prevention and Control Continued	Improve the uniformity, quality, and accessibility of emergency department (ED) data for public health surveillance in several States, ultimately developing the capacity to improve data in all States through development of guidelines, recommendations, or technical assistance	Establish the capability of state health departments to receive secure transmission of non-identifiable patient data from participating emergency departments.	Revised measure to be more outcome-oriented.
	Enhance the capacity of states to implement effective rape prevention and education programs	Develop case definitions for sexual assault.	Measure achieved
		Conduct state training programs	Measure achieved
	Reduce the number and severity of head injuries in CDC funded projects by increasing bicycle helmet use.	Reduce the number of bicycle-related emergency department visits by 5% per year from 123,475 in 1995.	Funding for this program shifted to other injury program priorities.
		Increase the use of bicycle helmets by child and teen bicyclists in CDC-funded project areas.	Partially Achieved--funding ended in FY 00
	Improve the timeliness and quality of data used to determine the medical and social impact of traumatic brain injury.	Develop a uniform reporting system for TBI; determine incidence and prevalence; report on uses of state surveillance and follow-up registry data; disseminate information on TBI trends	Reworded for FY03 plan to say "Increase the number of states receiving CDC funding for surveillance and to identify and track injuries."
		Implement CDC guidelines for design and use of TBI registries in 2 states by 2004; report outcomes associated with TBI.	Findings disseminated and measure achieved
	Reduce the incidence of residential fire-related injuries and deaths by increasing functional smoke alarms on every habitable floor.	The incidence of residential fire-related deaths will be reduced.	Reworded for FY03 plan to say "Among the state receiving funding from CDC, reduce deaths from residential fire."
Program Activity	Goal	FY 2002/03 Original Performance Measure	Revision and Explanation

Appendix F Change Chart

Injury Prevention and Control Continued		In CDC-funded projects within 14 states (our previous round of state projects), increase the proportion of homes with at least one smoke detector on each habitable floor.	Exceeded/measure achieved
		In CDC-funded projects within the 13 states, increase the number of homes with at least one smoke alarm on each habitable floor.	Measure achieved
		Publish recommendations for conducting and evaluating smoke alarm promotion programs.	Measure achieved
	Increase external input on the research priorities, policies, and procedures related to the extramural research supported by CDC.	Increase efficiency and effectiveness of research investments by employing competitive peer-review processes.	Reworded for FY 03 plan to say "Develop new or improved approaches for preventing and controlling death and disability due to injuries."
	Provide online access to injury prevention data	Implement a user-friendly, personal computer-based system for accessing Federal injury data in a variety of national and state-based systems.	Measure achieved
	Improve the uniformity, quality, and accessibility of emergency department (ED) data for public health surveillance in several States, ultimately developing the capacity to improve data in all States through development of guidelines, recommendations, or technical assistance.	Establish the capability of state health departments to receive secure transmission of non-identifiable patient data from participating emergency departments.	Reworded for FY03 plan to say "Increase the number of states receiving CDC funding for surveillance and to identify and track injuries."
Program Activity	Goal	FY 2002/03 Original Performance Measure	Revision and Explanation

Appendix F Change Chart

<p>Occupational Safety & Health Research</p>	<p>Conduct a targeted program of research to reduce morbidity, injuries, and mortality among workers in high-priority areas and high-risk sectors / Conduct a high quality research program in occupational safety and health which provides relevant, useful results to workers, employers, and other agencies on occupational diseases, workplace hazards, risk factors, and effective methods of prevention.</p>	<p>Expand involvement of other federal agencies in NORA-related research.</p> <p>Increase the science base for occupational safety and health through publications, innovations, and research partnerships.</p> <p>Demonstrate impact of NORA on research activity through bibliometrics and other proxy measures, such as accomplishments of NORA partnerships teams</p>	<p>Revised goal to coincide with Healthy People 2010 and President's Management Agenda</p>
	<p>New Performance Goal: Conduct a high quality research program in occupational safety and health that advances scientific knowledge and provides technically and economically utilizable results to workers, employers, governmental agencies, and the scientific community on workplace safety and health hazards, risk factors, and effective methods of prevention.</p> <p>Old Performance Goal: Conduct a high quality research program in occupational safety and health that advances scientific knowledge provides relevant, useful results to workers, employers, other agencies, and the scientific community on occupational diseases, workplace hazards, risk factors, and effective methods of prevention:</p>		<p>Revised overall performance goal to be more outcome oriented</p>
<p>Program Activity</p>	<p>Goal</p>	<p>FY 2002/03 Original Performance Measure</p>	<p>Revision and Explanation</p>

Appendix F Change Chart

<p>Occupational Safety & Health Continued</p>		<p>New Measure: Increase the relevance of occupational safety and health research for future improvements in workplace protection.</p> <p>Old Measure: Relevance of occupational safety and health research for future improvements in workplace protection.</p>	<p>Revised FY 03 and FY 04 measure to be more outcome oriented</p>
		<p>New Measure: Ensure the quality of occupational safety and health research as measured by peer review.</p> <p>Old Measure: Quality of research as measured by peer review.</p>	<p>Revised FY 03 and FY 04 measure to be more outcome oriented</p>
<p>Tracking Work Injuries, Illnesses, and Hazards (formerly surveillance section)</p>	<p>New Performance Goal: Increase the capacity for the collection and use of information on the occurrence and frequency of work injuries, illnesses, and hazards in order to access the actual burden of occupational injuries and illnesses.</p> <p>Old Performance Goal: Improve the quality (accuracy) of information and to increase the capacity for the collection and use of information on the occurrence and frequency of work injuries, illnesses, and hazards in order to keep target essential research and appropriate interventions for improvement of worker safety and health.</p>		<p>Revised overall performance goal to be more outcome oriented</p>
<p>Program Activity</p>	<p>Goal</p>	<p>FY 2002/03 Original Performance Measure</p>	<p>Revision and Explanation</p>

Appendix F Change Chart

<p>Occupational Safety & Health Continued</p>		<p>New Measure: Improve the quality and usefulness of tracking information by safety and health professionals and researchers in targeting research and intervention priorities; and measuring the success of implemented intervention strategies.</p> <p>Old Measure: Quality and usefulness of surveillance information by safety and health professionals and researchers in targeting research and intervention priorities; and measuring the success of implemented intervention strategies.</p>	<p>Revised FY 03 and FY 04 measure to be more outcome oriented</p>
<p>Information, Training, and Capacity Building (formerly Capacity Building section)</p>	<p>New Performance Measure: Ensure safer and healthier work environments for all Americans through information dissemination, knowledge transfer, and training.</p> <p>Old Performance Goal: Enhance the capacity to achieve a safe and healthy workplace for all Americans by assuring that there is an adequate supply of trained occupational safety and health professionals for the next decade, and enhancing knowledge and skill of employers, workers, and safety and health professional</p>		<p>Revised overall performance goal to be more outcome oriented</p>
<p>Program Activity</p>	<p>Goal</p>	<p>FY 2002/03 Original Performance Measure</p>	<p>Revision and Explanation</p>

Appendix F Change Chart

<p>Occupational Safety & Health Continued</p>		<p>Added New Measure: Increase quality, relevancy, and usefulness of NIOSH information and recommendations by occupational safety and health professionals, workers, employers, government, the scientific community, and the public.</p>	<p>Added new FY 03 and FY 04 performance measure that is outcome oriented and coincides with HHS outcome goal 4.4, 8.5</p>
<p>Prevention Activities through Evaluation, Safety and Health Interventions and Recommendations</p>	<p>New Performance Goal: Increase safety and health in the workplace by demonstrating, communicating, and promoting technically and utilizable solutions to control workplace hazards and reduce work-related injuries, illnesses, and fatalities.</p> <p>Old Performance Goal: Increase safety and health in the workplace by demonstrating, communicating, and promoting the use of effective solutions to control workplace hazards and reduce work-related injuries, and fatalities.</p>		<p>Revised overall performance goal that is more outcome oriented.</p>
		<p>New Measure: Reduce the annual incidence of work injuries, illnesses, and fatalities, in targeted sectors.</p>	<p>Created new performance measure to consolidate old performance measurements. New performance measure is outcome oriented and coincides with HHS outcome goal 1.6 and Healthy People 2010.</p>
<p>Program Activity</p>	<p>Goal</p>	<p>FY 2002/03 Original Performance Measure</p>	<p>Revision and Explanation</p>

Appendix F Change Chart

Occupational Safety & Health Continued		New Measure: Increased utilization of control technology and personal protective technology in targeted sectors	Created new performance measure to consolidate old performance measurements. New performance measure is outcome oriented and coincides with HHS outcome goal 2.2
		Old Measure: Reduce the annual incidence of disabling work injuries among children and youth.	Removed FY 03 and FY 04 performance measurement. FY 03 and FY 04 targets consolidated into new performance measurement.
		Old Measure: Reduce the annual incidence of needle stick injuries among hospital employees	FY 03 and FY 04 performance measure removed from plan by CIO during revision process
		Old Measure: Reduce the incidence and severity of silica exposures among construction workers.	Removed FY 03 and FY 04 performance measurement. FY 03 and FY 04 targets consolidated into new performance measurement.
		Old Measure: Reduce the annual incidence of material handling injuries among miners installing support structures	FY 03 and FY 04 performance measure removed from plan by CIO during revision process
		Old Measure: Reduce the annual incidence of musculoskeletal disorders among workers in the construction industry.	FY 03 and FY 04 performance measure removed from plan by CIO during revision process
		Old Measure: Reduce the percentage of damaged, field deployed, self-contained self-rescuers (SCSRs) (Type of respirator	FY 03 and FY 04 performance measure removed from plan by CIO during revision process, too output based.
Program Activity	Goal	FY 2002/03 Original Performance Measure	Revision and Explanation

Appendix F Change Chart

Occupational Safety & Health Continued		Old Measure: Increase the percentage of respirators users who have been trained how to use respirators for protection against potentially toxic work environments	FY 03 and FY 04 performance measure removed from plan by CIO during revision process, too output based
		Old Measure: Decrease average years of life lost to pneumoconiosis among U.S. workers	FY 03 and FY 04 performance measure removed from plan by CIO during revision process
		Old Measure: Reduce the annual incidence of elevated blood lead concentrations in persons due to work exposures	Removed FY 03 and FY 04 performance measurement. FY 03 and FY 04 targets consolidated into new performance measurement.
Surveillance	Identify high-risk working conditions by developing a surveillance system for major occupational illnesses, injuries, exposures, and health hazards / Improve the quality (accuracy) of information and to increase the capacity for the collection of information on the occurrence and frequency of work injuries, illnesses, and hazards so that the analysis of this information leads to essential research and appropriate intervention for improvement of worker health and safety.	Implement the strategic plan, and seek opportunities for enhancement via stakeholder interaction. Collect, analyze, and disseminate surveillance data on occupational illnesses, injuries, and hazards.	Revised goal
Program Activity	Goal	FY 2002/03 Original Performance Measure	Revision and Explanation

Appendix F Change Chart

<p>Occupational Safety & Health Continued</p> <p>Capacity Building</p>	<p>Foster safe and healthy working conditions by providing workers, employers, the public, and the occupational safety and health community with information, training, and capacity to prevent occupational diseases and injuries. / Enhance the capacity to achieve a safe and healthy workplace for all Americans by assuring that there is an adequate supply of trained occupational safety and health professionals for the next decade.</p>	<p>Transfer scientific and technical information to employers, workers, the public, and the occupational safety and health community.</p> <p>Conduct, arrange, and sponsor technology transfer and training sessions.</p> <p>Support capacity building activities.</p> <p>Support training for occupational safety and health professionals.</p> <p>Review a sample of documents, training materials, and communication efforts, and begin implementation of findings.</p>	<p>Revised goal to coincide with President's Management Agenda</p>
<p>Work Safety and Health Interventions</p>	<p>Promote safe and healthy working conditions by increasing occupational disease and injury prevention activities through workplace evaluations, interventions, and CDC recommendations. / Increase safety and health in the workplace by demonstrating, communicating, and promoting the use of effective solutions to control workplace hazards and reduce work-related injuries, diseases, and fatalities.</p>	<p>Respond to requests for workplace evaluations from employers, workers, and others, and provide practical advice to address problems.</p> <p>Provide scientific support for policy development, testimony, and non-regulatory initiatives.</p> <p>Evaluate the effectiveness of targeted prevention programs.</p>	<p>Revised goal to coincide with Health People 2010 objectives</p>
<p>Program Activity</p>	<p>Goal</p>	<p>FY 2002/03 Original Performance Measure</p>	<p>Revision and Explanation</p>

Appendix F Change Chart

Preventive Health and Health Services Block Grant	Provide interim dynamic support for high priority state and local disease prevention and health promotion programs.	Increase the number of grantees who submit as part of their annual report 1 health outcome impact success story.	Process measure
	Support high-priority state and local disease prevention and health promotion programs.	Increase the number of grantees who submit as part of their annual report 1 health outcome impact success story. Increase the number of grantees who submit both an annual application and annual report using the standardized electronic grant application and reporting system (GARS).	In the 2/02 submission, CDC has proposed adding these new measures. However, given the mandate to reduce the total number of measures in the performance plan, CDC withdrew these measures.
Public Health Improvement	Provide interim dynamic support for high priority state and local disease prevention and health promotion programs.	Increase the number of grantees who submit both an annual application and annual report using the standardized electronic grant application and reporting system.	Process measure
	Prepare local, frontline public health workers to respond to current and emerging public health threats.	Establish a national system of Centers for Public Health Preparedness to develop and dissemination competencies based public health curricula	Revised measure to be more outcome-oriented: Percent of states/terr. served by a center for public health preparedness(cphp) that provides education/training in BT and other public health threats and emergencies to frontline public health practitioners.
	Prepare local, frontline public health workers to respond to current and emerging public health threats.	Build capacity for technology based learning at Federal, State, and local levels	Revised measure to be more outcome-oriented: Percent of local health departments who deploy distributed learning technology in public health education and training.
Program Activity	Goal	FY 2002/03 Original Performance Measure	Revision and Explanation

Appendix F Change Chart

Public Health Improvement	Implement training programs to provide an effective workforce for U.S. health departments and laboratories and ministries of health in developing countries.	The number of public health professionals participating in distance learning activities will be increased.	Output-oriented - deleting measure. This information is already reported in the budget output table.
	Implement training programs to provide an effective workforce for U.S. health departments and laboratories and ministries of health in developing countries.	The number of Sustainable Management Development graduates who conduct training in developing countries will be increased.	Output-oriented - deleting measure. This information is already reported in the budget output table.
	Implement training programs to provide an effective workforce for U.S. health departments and laboratories and ministries of health in developing countries.	Evaluate the impact on laboratory practice of training programs conducted by the National Laboratory Training Network.	Moved to different goal (prepare frontline state and local health departments and laboratories to respond to current and emerging health threats) because it measures impact on lab practices
	Implement training programs to provide an effective workforce for U.S. health departments and laboratories and ministries of health in developing countries.	The number of states served by state and regional leadership development programs will be increased.	Output-oriented - deleting measure. This information is already reported in the budget output table.
	State and local health departments are able to electronically access and distribute up-to-date PH information and emergency health alerts, monitor the health of communities, and assist in detection of emerging public health problems.	Expand the connectivity of the Health Alert Network.	Moved from bioterrorism- This is a dual-use program between public health improvement and bioterrorism
	Conduct research to identify and evaluate community-based prevention interventions.	Disseminate research findings in formats that encourage uptake by decision-makers (clinicians, administrators, and legislators)	Process measure - deleting measure.
Program Activity	Goal	FY 2002/03 Original Performance Measure	Revision and Explanation

Appendix F Change Chart

Public Health Improvement continued	Strengthen the scope and nature of extramural public health research programs.	Expand the scope of public health research to multidisciplinary research efforts that bridge the gap between public health practice, public health research, bioethics, and health policy research.	Achieved and reported in FY 2001.
	Increase the number of frontline public health workers at the state and local level that are competent and prepared to respond to bioterrorism, other 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.	Percent of states/terr. Served by a Center for Public Health Preparedness (CPHP) that provides education training in BT and other public health threats and emergencies to frontline public health practitioners.	Consolidated measure Measure: Evaluate the impact on the performance/preparedness of frontline public health practitioners resulting from education and training programs implemented or supported by CDC, including the Centers for Public Health Preparedness system.
		Percent of local health departments who deploy distributed learning technology in public health education and training.	Consolidated measure Measure: Evaluate the impact on the performance/preparedness of frontline public health practitioners resulting from education and training programs implemented or supported by CDC, including the Centers for Public Health Preparedness system.
		States demonstrating improvement in laboratory testing and reporting of priority diseases.	Performance measure consolidated into one measure. Measure: Evaluate the impact on laboratory practice of the National Laboratory System (NLS) training programs conducted by the National Laboratory Training Network.
Program Activity	Goal	FY 2002/03 Original Performance Measure	Revision and Explanation

Appendix F Change Chart

Public Health Improvement continued	State and local health departments are able to electronically access and distribute up-to-date public health (PH) information and emergency health alerts, monitor the health of communities and assist in the detection of emerging public health problems.		Performance Goal 2 consolidated into Performance Goal 1 1. Increase the number of frontline public health workers at the state and local level that are competent and prepared to respond to bioterrorism, other 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.
Public Health Improvement - REACH	Improve the lives of racial and ethnic populations who suffer disproportionately from the burden of disease and disability, and develop tools and strategies that will enable the nation to eliminate these health disparities by 2010.	Fund selected communities to implement REACH 2010 interventions based on community planning activities.	CDC has historically met target. Measure will be deleted effective FY 03. CDC is eliminating this measure based on the mandate to reduce the total number of measures in the performance plan.
	Improve the lives of racial and ethnic populations who suffer disproportionately from the burden of disease and disability, and develop tools and strategies that will enable the nation to eliminate these health disparities by 2010.	Develop a comprehensive dissemination plan for transferring lessons learned from the REACH 2010 projects to communities across the country.	Measure will be deleted effective FY 03. CDC is eliminating this measure based on the mandate to reduce the total number of measures in the performance plan
	Improve the lives of American Indian and Alaska Native populations who suffer disproportionately from the burden of disease and disability, and develop tools and strategies that will enable the nation to eliminate these health disparities by 2010.	CDC will support AI/AN organizations to address health priorities, prevention gaps, and service delivery interventions for their communities.	Process measure. Eliminated effective FY 03. CDC will however continue to report on progress related to this measure in the performance summary
Program Activity	Goal	FY 2002/03 Original Performance Measure	Revision and Explanation

Appendix F Change Chart

Buildings and Facilities	Implement scheduled improvements, construction, security, and maintenance consistent with available resources and priorities identified in CDC's master facilities planning process.	Construct Phase II of Building 17 (Infectious Disease Research Laboratory) at the Clifton Road campus.	Deleting measure
		Design CDC buildings to begin building consolidation process	New/revised measure
		Construct CDC buildings	New/revised measure
		Design and construct a new Emerging Infectious Disease Laboratory, Building 18, Clifton Road campus, to vacate and modernize Building 1 South, house bioterrorism activities, and provide additional BSL-4 capacity.	Revised measure
		Begin design of a Scientific Communications Center to replace Building 2 and vacate and modernize Building 3, Clifton Road campus.	Revised measure
		Complete construction of infectious disease laboratory, Building 109, to replace Buildings 4, 6,7,8, and 9, Chamblee campus.	Revised measure
Office of the Director		Review and manage CDC's patent portfolio to maximize return for public health benefit.	Revised measure
		Complete construction of infrastructure project in Security Buffer Zone, Clifton Road campus.	Revised measure
		Design and construct an Environmental Toxicology Laboratory, Building 110, to replace Buildings 17, 25, 31, and 32, Chamblee campus.	Revised measure
Program Activity	Goal	FY 2002/03 Original Performance Measure	Revision and Explanation

Appendix F Change Chart

Office of the Director		Begin design of New Headquarters Building 21, Clifton Road campus, for lease consolidation project.	Revised measure
		Begin design of Building 106, Chamblee campus, for Lease Consolidation Project.	Revised measure
	Identify, evaluate, and protect novel technologies	Review and manage CDC's patent portfolio to maximize return for public health benefit	Revised for more outcome-oriented measure
		Increase the number of employee invention reports (EIRs) filed per year.	Deleting measure
	Facilitate the commercialization of unique technologies	Market all available licensing opportunities for CDC's intellectual property, and update availability of new technologies on a quarterly basis.	Deleting goal and measure.
		At least annually, provide new evidence that CDC licenses provide a substantial basis for development of commercially significant products and processes.	Deleting measure.
		Increase CDC outreach activities through participation in national and international research, trade, and technology transfer meetings/conferences.	Deleting measures.
	Promote private-sector participation and investment in applications of novel research discoveries.	Increase the number of CRADAs, Material Transfer Agreements, Clinical Trial Agreements, and other CDC-private sector research cooperation mechanisms.	Deleting goal and measure.
		Increase the number of EIRs arising from cooperative research with the private sector.	Deleting measure.
Program Activity	Goal	FY 2002/03 Original Performance Measure	Revision and Explanation

Appendix F Change Chart

Office of the Director continued	Increase public health scientists' knowledge and practice of human subjects protection in research.	Increase the number of states with assurances of compliance and IRBs.	Deleting goal and measure.
		Increase the number of CDC scientists who receive computer-based training in scientific ethics.	Deleting measure.
Minority Health	Prepare minority medical, veterinary, pharmacy, and graduate students for careers in public health	Increase the number of minority students participating in the Hispanic Health Professions Internship Program, Ferguson Emerging Infectious Disease Fellowship Program, Public Health Summer Fellowship Program, and Project IMHOTEP.	Deleting measure
	Foster a stronger collective departmental perspective on AI/AN issues	Working in conjunction with IHS, identify and pursue areas of mutual interest and benefit.	Deleting measure
OEEO	Enhance agency recruitment efforts to ensure the availability of applicant pools that include qualified minorities, women, and persons with disabilities	Increase our participation in the Agency's recruitment activities with HBCUs, HACUs, Tribal Colleges & Universities, Persons with Disabilities and build and expand other partnerships.	Deleting measure
	Provide continuing EEO and diversity training to managers, supervisors, and employees	Increase the opportunities for EEO Training for CDC/ATSDR workforce.	Deleting measure
	Through early intervention and Alternative Dispute Resolution (ADR), reduce the number of EEO complaints	Reduce the number of complaints in the inventory	Deleting measure
	Provide a tool to measure CIO performance and management accountability under the EEO Program.	Develop and disseminate an EEO report to each CIO quarterly.	Deleting goal and measure.
	Provide leadership and coordination for support activities across CDC.	Develop and provide technical assistance and consultation for CDC staff.	Deleting goal and measure.
Program Activity	Goal	FY 2002/03 Original Performance Measure	Revision and Explanation

Appendix F Change Chart

Office of the Director continued/ Program Planning and Evaluation		Coordinate the development and timely submission of correspondence, reports, and OMB clearance packages.	Deleting measure.
		Enhance the capacity of CDC policy staff to perform their official duties through training, team building, and sharing best practices, and promote better collaboration among policy teams.	Deleting measure.
	Improve CDC's Performance Plan	Develop and implement a formal process for evaluating performance goals and measures	Deleting measure.
		Develop and implement a formal process for evaluating performance goals and measures	Deleting measure.
		Develop and implement a process to ensure narrative goals and measures are more effectively linked to CDC's budget	Deleting measure.
	Effectively communicate CDC's scientific information to multiple audiences by increasing our understanding of each audience.	Develop an expedited OMB Clearance process that makes audience research/input more timely and do-able..	Delete measure.
		Expand capacity to obtain accurate and timely audience information which can be made available to all CDC programs and public health partners.	Delete measure.
Health Communication	Increase awareness of public health issues.	Develop a multi-tiered strategy for working with the private sector on communication initiatives.	Delete goal and measure.
Program Activity	Goal	FY 2002/03 Original Performance Measure	Revision and Explanation

Appendix F Change Chart

Health Communication continued		Build strong partnerships with national, international public health agencies, non-governmental agencies, and relevant private sector partners.	Deleting measure
		Develop a strategy for working with the news media on communicating about biological and chemical terrorist events.	Deleting measure
	To strengthen the science and practice of health, risk, and crisis communication through <i>research</i> .	Increase the amount of funds allocated for communication research and evaluation among CDC's programs and CDC's public health partners (through cooperative agreements, fellowships, or competitive grants processes).	Deleting measure
		Conduct research that advances the science and practice of risk and crisis communication in a Bioterrorism response.	Deleting measure
		Conduct research that advances the science of health communication and clearly indicates the contribution communication makes in health behavior change interventions.	Deleting measure
		Increase the number of publications authored by CDC communication professionals.	Deleting measure
	Strengthen the science and practice of health, risk, and crisis communication through <i>research and capacity building</i>		Deleting goal and measure
Terrorism	All goals	All FY 04 Measures are new	New measures
Program Activity	Goal	FY 2002/03 Original Performance Measure	Revision and Explanation

Appendix F Change Chart

Program Support	Enhance CDC's information security program and ensure that critical information systems and infrastructure operate reliably.	Protect CDC's information system and ensure the reliable and continuous operation of CDC's critical information systems and information technology infrastructure (data center, wide area network, e-mail, Internet/web services, and telecommunications).	New measure to consolidate related performance measures from the 5 areas of the President's Management Agenda (PMA) - measures below contribute to achieving a "green light" and will be monitored internally.
Information Access, Security, and Reliability	Provide a variety of standardized and integrated means for access to CDC information resources by health practitioners and the public.	Enhance CDC's information content and technology infrastructure to increase public access to CDC information resources through the CDC website and CDC's Voice/Fax Information Service (VIS).	Deleting measure
	Enhance CDC's information security program.	Protect CDC's information system from serious losses, alterations, or releases of data or information that are critical, highly sensitive, or covered by privacy or confidentiality requirements.	Consolidated/revised measure
	Ensure that critical information systems and infrastructure operate reliably.	Ensure the reliable and continuous operation of CDC's critical information systems and information technology infrastructure (data center, wide area network, e-mail, Internet/web services, and telecommunications).	Consolidated/revised measure
Program Activity	Goal	FY 2002/03 Original Performance Measure	Revision and Explanation

Appendix F Change Chart

Program Support	Identify, evaluate, and protect novel technologies.	Review and manage CDC's patent portfolio to maximize return for public health benefit.	Less than 30 percent of unlicensed patents are being maintained by CDC beyond 4 years from the date of issue. Upon further analysis, this is not a valid measure of technology transfer. It is an arbitrary measure that may not reflect the public policy needs of the agency to invest in solutions to anticipated problems or the "ahead of their time" nature of CDC inventions.
<i>Competitive Sourcing, Financial Assistance, and Performance-Based Contracting</i>	Implement competitive sourcing for analyzing and conducting program activities that are commercial in nature.	Directly convert to contract and/or conduct cost comparison studies of CDC staff performing commercial functions listed in the CDC FAIR Act inventory.	Deleting measure
	Establish performance measures for grants and cooperative agreements.	Document grantee performance relevant to the purpose of Program Announcements, Healthy People 2010 Goals and appropriate Programmatic GPRA goals by incorporating performance measures into Program Announcements.	Deleting measure
	Streamline financial assistance programs (grants and cooperative agreements) through consolidation.	Consolidate competitive grant and cooperative agreements through the use of umbrella Program Announcements.	Deleting measure
	Enhance the effectiveness of service contracts through performance-based contracting.	Increase the use of performance-based contracting.	Deleting measure
<i>Financial Management</i>	Ensure the proper preparation and presentation of CDC's financial statements.	Achieve 100% audited financial statements with no qualifications.	Deleting measure
Program Activity	Goal	FY 2002/03 Original Performance Measure	Revision and Explanation

Appendix F Change Chart

Program Support Recruitment Timeliness	Decrease the time needed to classify positions and refer candidates for vacancies.	Decrease the time needed to refer candidates to fill positions	Deleting measure
Workforce Planning	Enhance workforce planning efforts at CDC	Improvement of supervisory ratio	Deleting measure
		Increase in the span of control and organizational size.	Deleting measure
		Reduction in the number of organizational units.	Deleting measure
SES Performance Contracts	Development and implement SES Performance Contracts.	Development and implementation of SES Performance Contracts	
Recruitment and Retention Strategies	Increase Hispanic/Latino representation at CDC	Increase percentage of Hispanic/Latino representation in the workforce.	
	Recruitment and retention of a highly qualified workforce.	Use of above the minimum appointments to attract superior candidates.	
		Use of recruitment bonuses for hard-to-fill positions.	
		Use of retention allowances to retain essential employees.	