Performance Highlights

U.S. Department of Health and Human Services

February 4, 2008

Message from the Secretary

The HHS's Mission
The mission of the Department of Health and Human Services is to enhance the health and well-being of Americans by providing for effective health and human services and by fostering strong, sustained advances in the sciences, underlying medicine, public health, and social services.

During FY 2007, the Department of Health and Human Services (HHS) continued to fulfill its charge to protect the health of all Americans and provide essential human services, especially for those who are least able to help themselves. This Performance Highlights report presents a summary of key past and planned performance and financial information of the Department. Two topics are particularly important to highlight:

1) **Health Care**
   While the majority of Americans get their health coverage through their workplace or from public programs like Medicare, Medicaid and the State Children's Health Insurance Program (SCHIP), improving access for the forty-seven millions Americans currently without health insurance presents a very large challenge to policymakers. During FY 2007, the Department made progress on several fronts. For example, the Health Resources and Services Administration funded 337 new or significantly expanded health care sites. There are now more than 4,000 service delivery sites nationwide providing care to an estimated 16.1 million patients in urban and rural areas with insufficient access to care. After the first year of the Medicare Part D program, approximately 90 percent of Medicare beneficiaries had prescription drug coverage from Part D or other sources during FY 2006. Part D has generated significant savings to beneficiaries, averaging $1,200 annually. During FY 2009, the Department will continue its efforts to reform the health care marketplace by fostering affordable choices in the health care system and proposing increased funding for SCHIP, focused on low-income children.

2) **Public Health**
   HHS prevention efforts are an important component of public health protection. For example, food borne illnesses are a substantial health risk in the United States, with surveillance data indicating that each year 76 million Americans suffer illness from food they consume. Although the incidence of some common food borne illness has declined since the baseline period (1996—1998), other types of food illnesses have increased and Americans rely more than ever on the global food supply. Both are indicators of the need for further measures to prevent food borne illness and achieve national health objectives. The FY 2009 Budget continues to expand the investment in food safety.

With the implementation of a more modern financial management system, HHS has made significant progress toward ensuring that reliable and timely information is available for decision-makers. For the ninth consecutive year, HHS earned an unqualified or "clean" audit opinion on the Department's consolidated financial statements. The financial and performance data presented in this report, and the agencies' Congressional Justifications and Online Performance Appendix is reliable, complete, and provides the latest data available, except when otherwise noted, and demonstrates the Department's commitment to ensuring the highest measure of accountability to the American people. Additional information can be found at http://www.hhs.gov/budget/docbudget.htm.

HHS's accomplishments would not have been possible without the dedication and commitment of its employees and partners. They should be very proud of the positive impact their contributions have on the lives of Americans. Together we will continue to strive to enhance the health and well-being of the American people.

Michael O. Leavitt
Secretary

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Introduction

This document summarizes key past and planned performance and financial information. It is organized by the Department of Health and Human Services' (HHS') Strategic Goals and Objectives, which are contained in HHS' recently-released five-year Strategic Plan, available at www.aspe.hhs.gov/hhsplan/2007/. HHS' four Strategic Goals are:

- Strategic Goal 1: *Health Care* – Improve the safety, quality, affordability, and accessibility of health care, including behavioral health care and long-term care.
- Strategic Goal 2: *Public Health Promotion and Protection, Disease Prevention, and Emergency Preparedness* – Prevent and control disease, injury, illness, and disability across the lifespan, and protect the public from infectious, occupational, environmental, and terrorist threats.
- Strategic Goal 3: *Human Services* – Promote the economic and social well-being of individuals, families, and communities.
- Strategic Goal 4: *Scientific Research and Development* – Advance the scientific and biomedical research and development related to health and human services.

The *Performance Highlights* presents the measures that HHS uses to support each Strategic Goal. As you read about each measure, you will find:

- A short description of the program responsible for the measure;
- A chart with past and projected future performance;
- A discussion of trend data, with a brief description of future plans and strategies. If a target was missed, a brief explanation will be included;
- A summary of key management issues; and
- Information pertaining to each measure's data source.

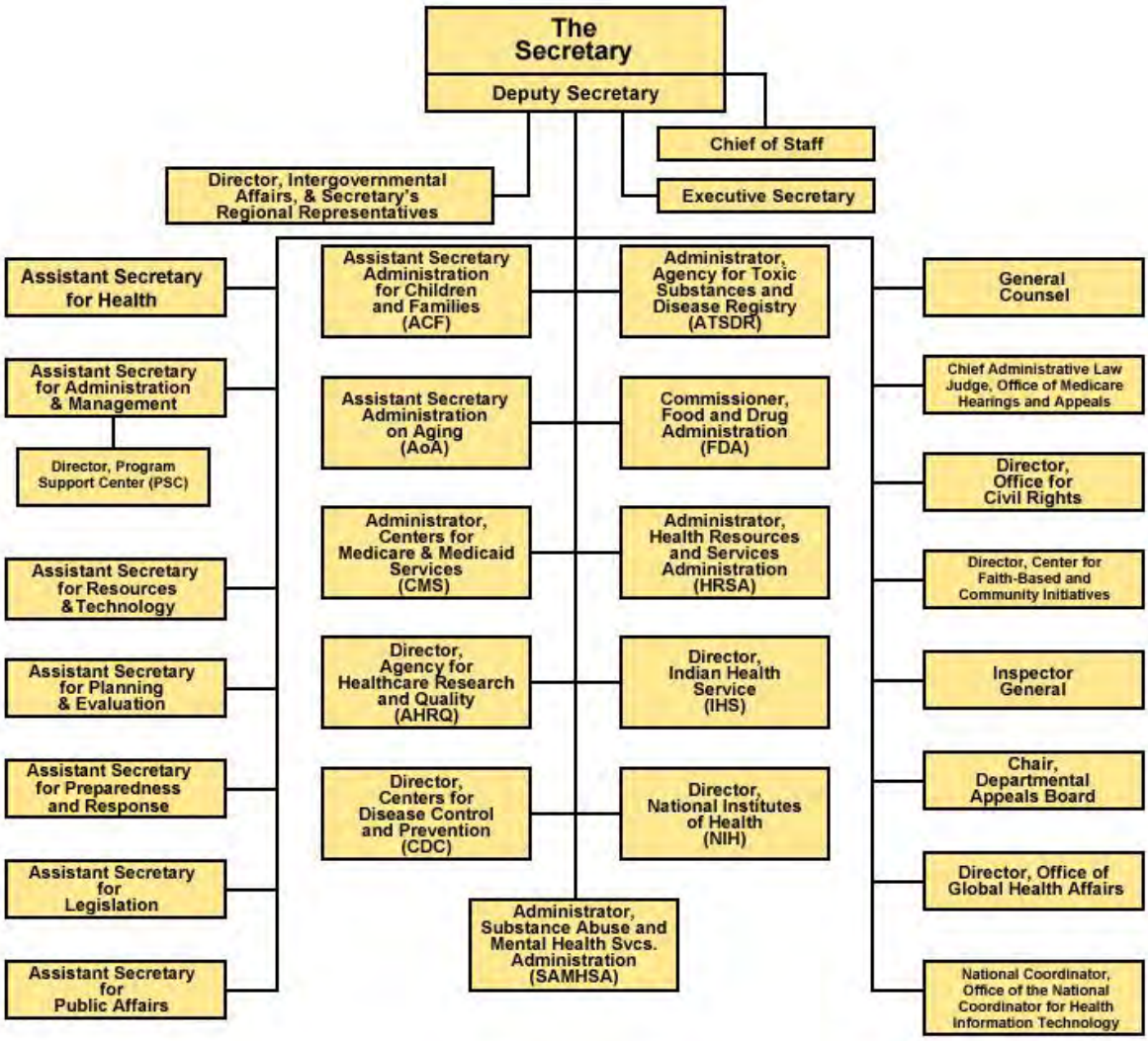
This document also includes summary information from financial statements published in the Fiscal Year (FY) 2007 Agency Financial Report, available at www.hhs.gov/afr/index.html. In addition, the Appendix section includes a matrix linking each HHS Operating Division to the HHS Strategic Goals; the Department's full cost by strategic goal; summaries of HHS' results from the Program Assessment Rating Tool, the President's Management Agenda, and the Departmental Management Challenges identified by the Office of the Inspector General; and links to sources of additional information.

The *Performance Highlights* is one of several documents that fulfill the Department of Health and Human Services' performance planning and reporting requirements. HHS achieves full compliance with the Government Performance and Results Act of 1993 and Office of Management and Budget Circulars A-11 and A-136 through HHS agencies' FY 2009 Congressional Justifications and Online Performance Appendices, the Agency Financial Report and the HHS Performance Highlights. These documents can be found at: http://www.hhs.gov/budget/docbudget.htm and http://www.hhs.gov/afr/.

The HHS' FY 2007 Annual Performance Report and FY 2009 Annual Performance Plan are fully integrated into the various volumes of the Department's FY 2009 Congressional Justifications. Additionally, the Congressional Justifications are supplemented by Online Performance Appendices. Where the Justifications focus on key performance measures and summarize program results, the Appendices provide performance information for all HHS measures, and provide more detailed information. These documents can be found at: http://www.hhs.gov/budget/docbudget.htm.

HHS Organizational Chart

The Secretary leads a Department that provides a wide range of services and benefits to the American people. Below is an organizational chart. Further details concerning each major Departmental component's role in accomplishment of the overall mission and strategic goals are discussed in the Strategic Goal sections of the document, as well as in the HHS Strategic Plan, and the HHS Congressional Justifications, which can be found at *www.hhs.gov*.

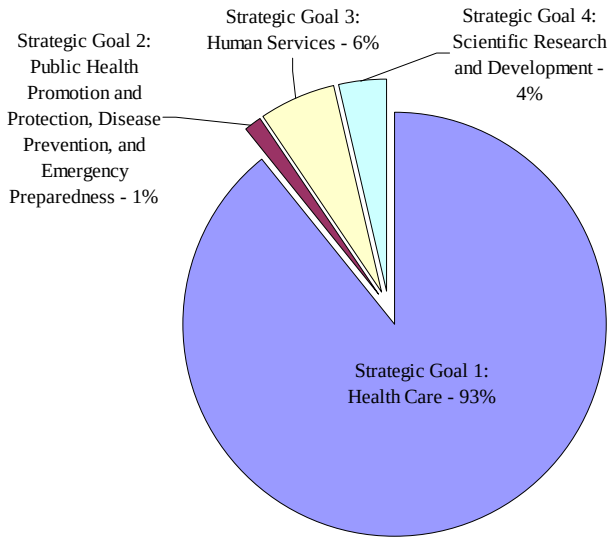


**Click the desired organizational box to be linked to the appropriate website.*

Performance Highlights

Through its eleven Operating Divisions and fifteen Staff Divisions, HHS implements over 300 programs affecting the health, safety, and welfare of every American. Detailed information about each HHS program and their associated performance measures can be found in each HHS agency FY 2009 Congressional Justification and Online Performance Appendix, available at: www.hhs.gov/budget/docbudget.htm.

The distribution of the FY 2009 President's Budget by HHS Strategic Goal is shown in the pie chart to the right. Forty measures from throughout HHS are included in the Strategic Plan, selected because they represent the major contributors to the Department's strategic goals. These measures, and related successes and challenges, are discussed in the following pages organized by Strategic Goal and Objective. For more information about any of the programs covered in this document, please see the respective HHS agency website link available at: www.hhs.gov/about/index.html.



FY 2009 Budget by HHS Strategic Goal

The success of HHS' programs is gauged through the over 800 performance measures tracked by the Department. While this document reports on FY 2007 performance, HHS does not yet have this year's data for some programs' measures due to data lag. The Department is often challenged with data lag associated with its measures since many programs operate through grants that are directly managed by various organizations and State governments. The table below shows HHS' overall progress in meeting its over 800 performance measures. For FY 2007, only 43% of HHS' performance measures are currently able to report data. Of these, 80% met their targets. As results become available, HHS continues to meet a large percentage of its targets, which is notable considering the size and scope of the Department. For example, with 97% of measures in FY 2004 reporting data, HHS met an impressive 81% of performance targets for that year. In the pages that follow, we have provided the most recent data available for each measure, including its targets and results. Some measures are newly developed and may lack established baselines or annual targets. In these cases, we are reporting any result available, until we have collected enough data to establish targets. In other cases, we are able to report historical data for newly established measures to place results in context. Where appropriate, we provide an explanation of the missing data and/or targets. Details concerning data validation for each measure can be found at the end of each agency's Online Performance Appendix, available at: www.hhs.gov/budget/docbudget.htm.

Fiscal Year	HHS Total Measures	Measures with Results Reported		Measures with Results Reported and Met Targets	
		Number	%	Number	%
2004	607	591	97%	477	81%
2005	654	631	96%	517	82%
2006	734	660	90%	518	78%
2007	826	358	43%	288	80%

Strategic Goal 1: Health Care

Improve the safety, quality, affordability, and accessibility of health care, including behavioral health care and long-term care.

The four broad objectives under *Health Care* are:

- Objective 1.1: Broaden health insurance and long-term care coverage;
- Objective 1.2: Increase health care services availability and accessibility;
- Objective 1.3: Improve health care quality, safety, cost, and value; and
- Objective 1.4: Recruit, develop, and retain a competent health care workforce.

Today, disease, illness, and disability can be as much of a threat to Americans' financial well-being as they are to Americans' physical and mental well-being. Health care spending in America has increased from five percent of Gross Domestic Product (GDP) in 1960 to more than 16 percent in 2006 and is expected to continue to rise.[1] The increasing burden of health spending on the U.S. economy is unsustainable, with higher spending on public programs such as Medicare and Medicaid straining Federal and State budgets, and higher insurance premiums burdening workers with higher health costs and posing a challenge to employers. Additionally, 47 million Americans do not have health insurance.[2] These individuals may face barriers to obtaining timely and continuous care. Because of their limited access to the system, their health problems may become more severe and further increase health care costs.

During FY 2007, the Department moved forward towards meeting this challenge in several fronts. For example, CMS is exploring innovative ways to make the Medicaid program more sustainable over time by increasing the number of individuals transitioning from institutions to communities, promoting private long-term care insurance coverage, and working with States to give Medicaid beneficiaries access to modern health insurance products. In 2007, efforts began to provide incentives to physicians voluntarily reporting quality measures, and information collected through these efforts will become the basis for bonus payments in 2008. Price information for medical procedures under Medicare is now updated on an annual basis. We have also expanded access to care for the Nation's low-income, underserved, and medically vulnerable populations. In FY 2007, the Health Resources and Services Administration expanded health care sites to more than 4,000 service delivery sites nationwide. During FY 2009, the Department will continue its efforts to reform the health care marketplace by fostering affordable choices in the health care system, and proposing increased funding to SCHIP, focused on low-income children.

The table below shows HHS' progress in meeting targets for Strategic Plan measures for Strategic Goal 1 in this document.

Fiscal Year	Total Targets	Targets with Results Reported			
		Number with Results	%	Number Met	%
2004	5	5	100%	0	0%
2005	6	6	100%	4	67%
2006	8	5	63%	5	100%
2007	9	5	56%	4	80%

[1] Lewin Group. (2005). *Health Information Technology Leadership Panel Final Report.* Available at www.hhs.gov/healthit/HITFinalReport.pdf

[2] United States Census Bureau, Housing and Household Economic Statistics Division.(2007). *Health Insurance Coverage: 2006.* Available at www.census.gov/hhes/www/hlthins/hlthin06/hlth06asc.html

Performance Measure: Implement the Medicare Prescription Drug Benefit – Increase the percentage of Medicare beneficiaries with prescription drug coverage from Part D or other sources.

Description: Medicare finances health insurance for eligible elderly and disabled individuals. As of January 1, 2006, the Medicare benefit includes outpatient prescription drug coverage (Part D).

Performance: After the first year of the Medicare Part D program, calendar year (CY) 2006, approximately 90 percent of Medicare beneficiaries had prescription drug coverage from Part D or other sources. The Centers for Medicare and Medicaid Services (CMS) will report CY 2007 enrollment data in February 2008.

Given the initial success of the program, enrollment rates are likely to slow down somewhat because remaining non-enrollees are those who are very hard to reach or who have made a choice not to enroll. CMS continues to take steps to educate, inform, and protect beneficiaries. Such steps include: making information available at www.medicare.gov, where beneficiaries can review and compare all of the health and prescription plans available in their area; and ensuring that people who do not have computer access can get the same information 24 hours a day, 7 days a week at 1-800-MEDICARE or by reviewing the information that was included in the Medicare & You handbook that was mailed earlier in Fall 2007.

Because the drug benefit is new, the first annual target will be set for CY 2009. CMS will base the CY 2009 target on CY 2006-2007 enrollment data. CMS also has a CY 2012 target of 93 percent that was developed in the preparation of the HHS strategic plan.*

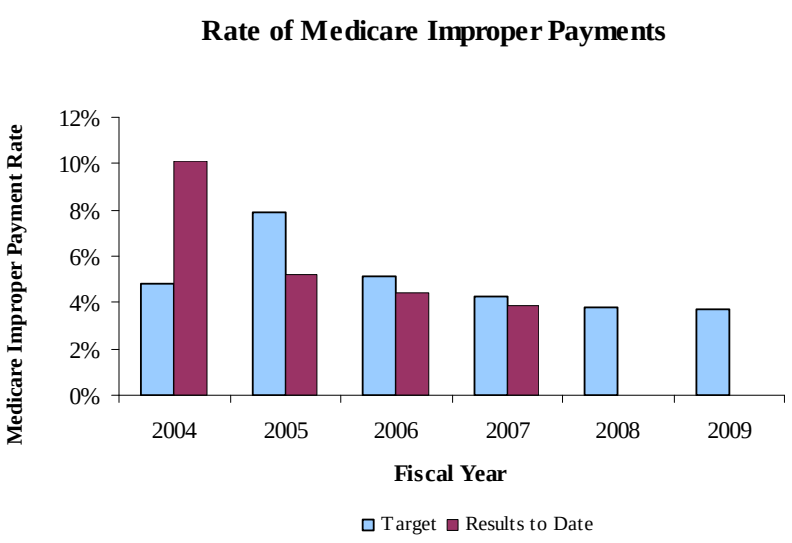
Data Source: The data for this measure is from CMS' Management Information Integrated Repository and updates from other external data sources.

*There is no chart of data displayed here since there is only one year of trend data for this measure.

<u>Performance Measure</u>: Reduce the percentage of improper payments made under the Medicare fee-for-service (FFS) program.

Description: The Centers for Medicare & Medicaid Services' (CMS) Medicare Integrity Program (MIP) safeguards the Medicare Trust Funds against fraud, waste and abuse. MIP conducts reviews and investigations of Medicare expenditures to ensure Trust Fund resources are utilized properly for Medicare's mission.

Performance: The improper payment rate measures the percentage of payment dollars that are overpayments or underpayments. This rate is estimated based on data from the two Medicare FFS measurement programs: the Comprehensive Error Rate Testing (CERT) program and the Hospital Payment Monitoring Program (HPMP). Using these data sets to manage Medicare contractors, identify and prevent improper payments, and educate providers that bill CMS programs, the program has successfully reduced the FFS improper payment rate from 10.1 percent in FY 2004 to 3.9 percent in FY 2007.



The FY 2007 rate of 3.9 percent was better than the FY 2007 target of 4.3 percent. In light of this, CMS adjusted the target for FY 2008 to 3.8 percent and the target for FY 2009 to 3.7 percent to pursue continued reductions in the FFS improper payment rate. CMS will continue to use the CERT program to hold the FFS contractors accountable for the services they provide as CMS moves from contracts that simply pay contractors to process Medicare claims to performance-based contracts. CMS expects that operational changes occurring in the Medicare program will affect the improper payment rate in upcoming years. These changes include the transition of Medicare FFS contracts from carriers and fiscal intermediaries to Medicare Administrative Contractors and the consolidation of the HPMP and CERT programs. Since the impact of these changes can not be predicted precisely, CMS will establish the FY 2012 target in FY 2009.

The improper payment rate has already been reduced substantially, and therefore CMS will need targeted strategies to achieve further reductions. CMS will pursue strategies directed at specific regions, providers, and error types. These strategies include developing new data analysis procedures to identify payment aberrancies and using that information to preemptively stop improper payments. CMS will also direct Medicare contractors to develop local efforts to lower the improper payment rate by creating plans that address the problems the root causes of errors.

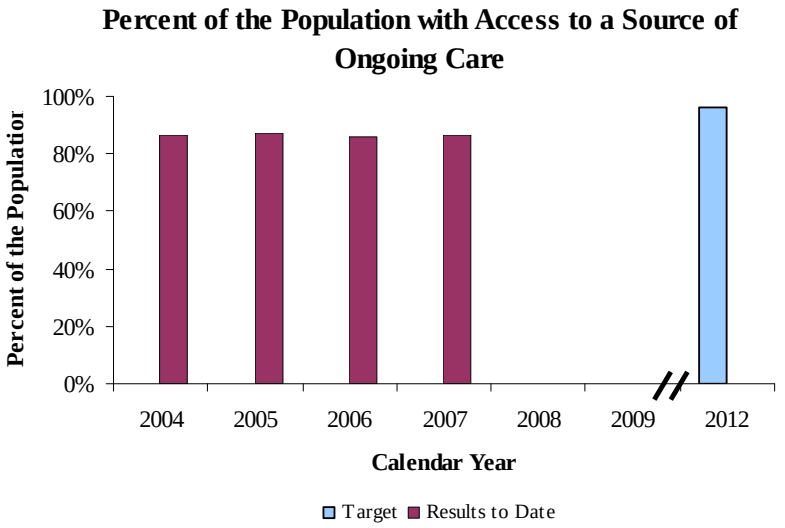
Data Source: The data for this measure is from CMS' CERT and HPMP programs.

<u>Performance Measure</u>: Increase the number of persons (all ages) with access to a source of ongoing care.

Description: The Health Resources and Services Administration (HRSA) is one of the principal Federal agencies charged with improving access to health care for people who are uninsured, isolated, or medically vulnerable. HRSA programs provide access to a variety of health care services, including those targeting vulnerable and underserved populations.

Performance: Healthy People 2010 and the HHS Strategic Plan established a long-term goal to ensure that 96 percent of all people have access to a source of ongoing care by 2012. The long-term approach encourages collaboration at the Federal, State and local levels to meet national goals and objectives; consequently, there are no annual targets for this measure.

Data from the previous four years show a relatively steady state for persons with sources of ongoing care, hovering just below 87 percent. The 2006 National Health Interview Survey indicates that 86.2 percent of people had access to a source of ongoing care. Preliminary data for 2007 show 86.6 percent of people had a source of ongoing care, demonstrating a slight improvement over 2006. Any progress toward the target for individuals with a source of ongoing care may be attributed to many factors, including the continued expansion of HRSA's Health Center Program.



There are many challenges to achieving the long-term goal of providing health care access to 96 percent of all people. Nearly 40 million people have no primary source of health care. These individuals face a variety of barriers to receiving care, including poverty, homelessness, lack of insurance, language barriers, geographic isolation, and a lack of affordable transportation options. In fact, nearly 47 million individuals do not have health insurance. These individuals are far more likely than those with insurance to report problems in getting needed medical care.

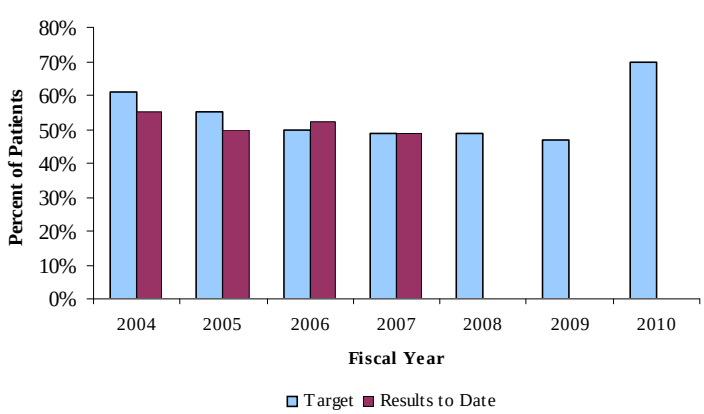
In order to address some of these challenges, HRSA is continuing the President's Health Center Initiative, which served nearly six million uninsured individuals in 2006. Began in 2002, this initiative has substantially increased both the number of communities with access to care and the number of people able to get the care they need. The number of Health Center service delivery sites has grown to more than 4,000 across the United States. The number of patients served by Health Centers continues to increase through expansion activities supported by the Initiative, and in FY 2009, HRSA plans on serving 17.1 million patients, among which will be seven million uninsured individuals. HRSA is also continuing to provide national leadership in the development, distribution, and retention of a diverse, culturally-competent health workforce, including investments in the National Health Service Corps, which helps to reach individuals in underserved areas.

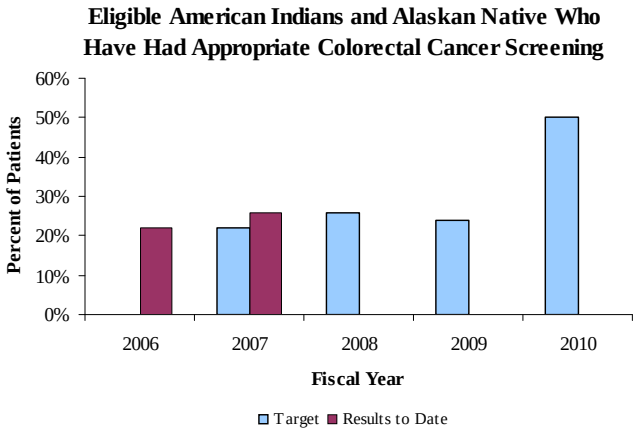
Data Source: The data for this measure is from National Health Interview Survey, conducted by the Centers for Disease Control and Prevention.

<u>Performance Measure</u>: Increase the proportion of (1) American Indian and Alaska Native patients with diagnosed diabetes who receive an annual retinal examination; and (2) Increase the proportion of eligible American Indian and Alaska Native patients who have had appropriate colorectal cancer screening.

Description: Expanding access to health screenings for American Indians and Alaska Natives is a collaborative effort between the Indian Health Service (IHS) and Tribes in order to prevent and reduce the complications of chronic disease and promote improved health.

Performance: Early detection of diabetic retinopathy (DR) is a fundamental and critical part of the effort to reduce visual loss among people with diabetes. In FY 2006, IHS increased the proportion of diabetic patients who received an annual diabetic retinal exam at designated demonstration sites using specified technologies to 52 percent from 50 percent the previous year. This measure changed in FY 2006 for reporting DR screening rates of Tele-ophthalmology demonstration sites to reporting the rate of all sites, regardless of the type or use of technology. In FY 2007, 49 percent of patients received annual retinal examinations at all sites, which met the target. For FY 2008, the challenge for the Indian Health Service in DR screening is to maintain previous year performance in the face of increases in diabetes prevalence and the steadily increasing optometry program vacancy rates. The Indian Health Service will face these challenges by improving performance through heightened attention to DR, disseminating best practices of high performing sites, and continued expansion of the IHS-Joslin Vision Network Tele-ophthalmology program. For FY 2009, the target is 47 percent.





Research shows that yearly screening for colorectal cancer may reduce colorectal cancer mortality by 33.4 percent. In FY 2006, IHS added colorectal cancer screening as a performance measure with a baseline rate of 22 percent. The FY 2007 results show that 26 percent of eligible patients received colorectal cancer screenings, which exceeds the baseline by 4 percent. This result was attained because IHS targeted the potential impact of colorectal screening to reduce mortality rates and health care costs. In FY 2008, IHS plans to maintain the 26 percent screening rate. The FY 2009 performance target of 24 percent reflects a two percent decrease due to the fact that colorectal cancer screening is a high-cost procedure that often cannot be provided within the IHS system. Many facilities rely on contract health services to pay for the colorectal cancer screenings provided by the private sector.

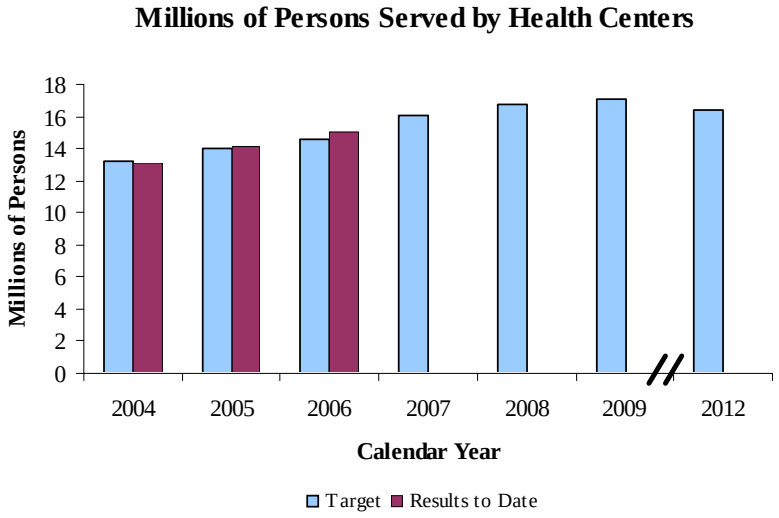
Data Source: The data for this measure is from the IHS Clinical Reporting System.

Performance Measures: Increase the number of patients served by Health Centers.

Description: The Health Centers Program provides grants to community-based organizations to deliver comprehensive, high quality, and cost-effective primary health care to populations in urban and rural areas that lack access to care.

Performance: Since 2002, the number of patients served by Health Centers has increased an average of 920,000 persons per year, reaching over 15 million patients in 2006. This growth was fueled by the President's Health Centers Initiative, which was designed to significantly impact communities through the support of 1,200 new access points and significantly expanded sites.

In 2006, Health Centers served 15 million patients, exceeding the target of 14.6 million by 380,000 persons. In 2007, the President's Health Centers Initiative funded 337 new and expanded sites, including 80 sites in high-poverty areas, bringing the total to 1,236 new and expanded sites since the beginning of the Initiative in 2002. The program is estimated to serve 16.1 million and 16.8 million patients in 2007 and 2008, respectively. In 2009, the Health Centers Program expects to provide care to 17.1 million patients and fund up to 40 new sites in high poverty areas.



Growth in the number of patients served is dependent upon factors such as: continued funding for new Health Center organizations, growth in the capacity and efficiency of existing centers, policies of the Medicaid program and other State programs that support care to the uninsured and public awareness of the availability of Health Center services. By providing technical assistance to Health Center organizations on improving quality of care, achieving efficiency of operations, and conducting outreach to the public, Health Centers are able to overcome some of these challenges and contribute to the growth in the number of communities and individuals with access to primary and preventive health care.

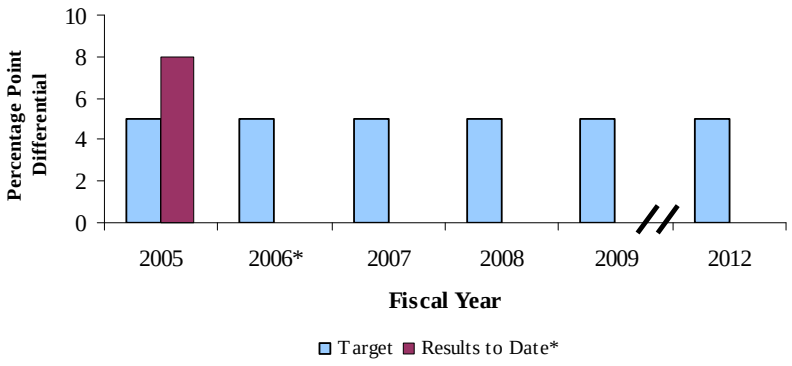
Data Source: The data for this measure, which has a two year data lag, is from the HRSA Bureau of Primary Health Care Uniform Data System.

<u>Performance Measure</u>: Serve the proportion of racial/ethnic minorities in programs funded through the Ryan White HIV/AIDS Program at a rate that exceeds their representation in national AIDS prevalence data.

Description: The Ryan White HIV/AIDS Treatment Modernization Act of 2006 addresses the unmet care and treatment needs of persons living with HIV/AIDS who are uninsured or underinsured. The services provided are intended to reduce the use of more costly emergency services and inpatient care, increase access to care for underserved populations, and improve the quality of life for those infected or affected by the epidemic.

Performance: The Ryan White HIV/AIDS Program works to improve access to HIV/AIDS treatment and care for all individuals, especially those disproportionately impacted by HIV/AIDS such as racial and ethnic minorities and women. By serving a proportion of racial/ethnic minorities and women that exceeds their representation in national AIDS prevalence data as reported by the Centers for Disease Control and Prevention (CDC), the Ryan White HIV/AIDS Program demonstrates its effectiveness in actively identifying and enrolling those people who data indicate have the greatest unmet care and treatment needs.

Difference in Racial/Ethnic Minority Representation Between Ryan White Service Population and National AIDS Surveillance Data



In 2005, 72 percent of Ryan White HIV/AIDS clients were racial/ethnic minorities. This is a significantly higher proportion than their representation (64 percent) among CDC reported AIDS cases. This result exceeds the target of serving five percentage points above the CDC data, largely due to increased efforts directed at the populations most at risk. In 2006, 72 percent of the Ryan White HIV/AIDS Program clients were racial/ethnic minorities, but the comparison data from CDC is not yet available. The FY 2008 and FY 2009 targets are to serve a proportion of racial/ethnic minorities that is 5 percentage points above the CDC-reported AIDS prevalence data for each year.

The Program strives to address disparities in access to essential services for racial/ethnic minorities who are disproportionately impacted by the HIV/AIDS epidemic, while also providing needed services to eligible persons in non-minority racial/ethnic groups. Ongoing challenges in meeting the performance target include the following: many persons are unaware of their serostatus; persons who know they are infected may be reluctant to seek HIV/AIDS care; and persons may be unaware of the availability of Ryan White HIV/AIDS Program services. Strategies that providers have adopted include targeted outreach, testing, and follow-up activities to high-risk groups.

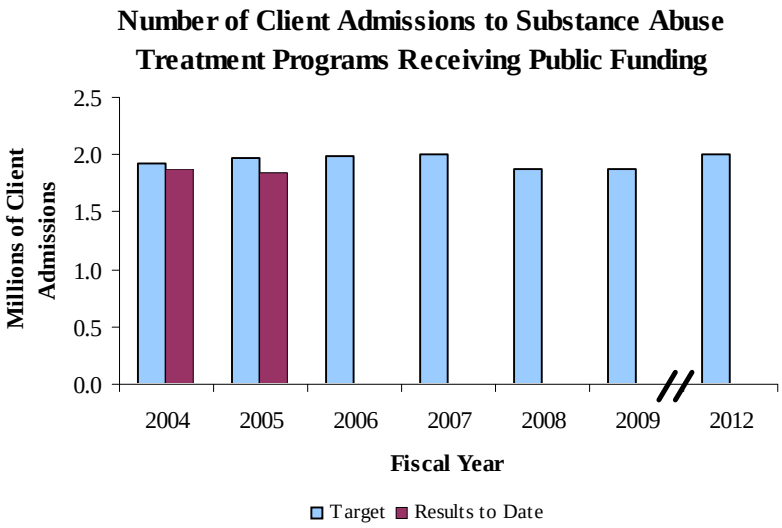
Data Source: The data for this measure is from the Health Resources and Services Administration's Ryan White HIV/AIDS Program data and the CDC.

*At this time, FY 2006 HRSA data is available, but comparison CDC data is not available.

<u>Performance Measure</u>: Increase the number of client admissions to substance abuse treatment programs receiving public funding.

Description: The Substance Abuse Prevention and Treatment Block Grant provides funding to States to plan, carry out, and evaluate activities to prevent and treat substance abuse.

Performance: The number of client admissions to substance abuse treatment programs remained slightly below 1.9 million from FY 2002 through FY 2005. Modest fluctuations in the number of client admissions in these years can be attributed to changes in the number of treatment facilities in operation in the States. The number of client admissions in FY 2005 was one percent below the number of admissions in the prior year, and was six percent below the target set for FY 2005. This reduction, and a decrease in the FY 2008 and FY 2009 targets, is associated with a decrease in the number of providers, which resulted from increased costs of doing business and relative decreases in the availability of resources. Data is not yet available for FY 2006, as there is a data lag of approximately two years associated with data collection, cleaning, and analysis.



For FY 2009, the target is 1.9 million client admissions, an increase of two percent over the most recent performance result. For the longer term, a target has been established to achieve 2.0 million client admissions by FY 2012, representing an eight percent increase over the most recent performance result.

The Substance Abuse and Mental Health Services Administration (SAMHSA), which administers the Substance Abuse Prevention and Treatment Block Grant, is working in collaboration with critical stakeholders to disseminate important innovations to improve the availability and cost effectiveness of services. SAMHSA is also working with its partner agencies at the National Institutes of Health to disseminate evidence-based practices related to improving access and reducing overall treatment costs.

Data Source: The data for this measure comes from the Treatment Episode Data Set component of the SAMHSA Drug and Alcohol Services Information System, and has a two year data lag.

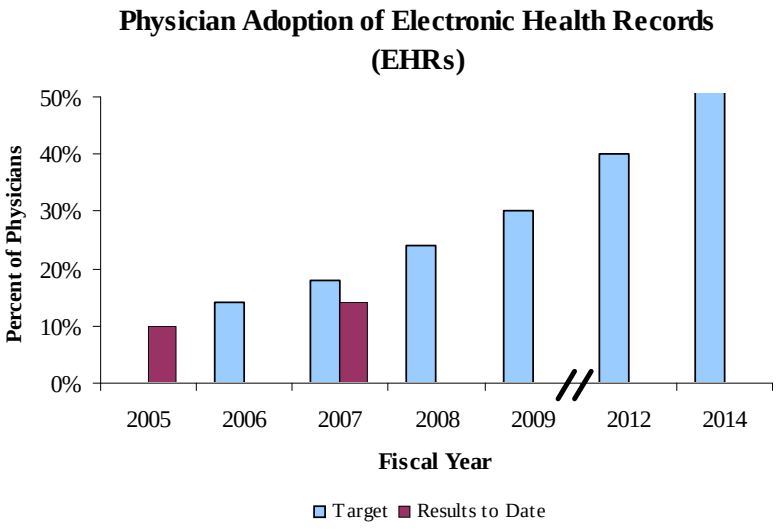
Performance Measure: Increase physician adoption of Electronic Health Records (EHR).

Description: The Office of the National Coordinator for Health Information Technology (ONC) executes the necessary strategic planning, coordination, and analysis related to the public and private adoption of health information technology (IT).

Performance: The President called for most Americans to have access to EHRs by the year 2014. Health IT is a critical component in improving the quality, safety, cost and value of health care offered to our Nation's 300 million Americans. To further the ability of health IT to improve the quality and efficiency of services, the Centers for Medicare & Medicaid Services (CMS) will execute a demonstration project to provide financial incentives for physician practices to adopt certified EHR systems.

To measure progress towards the President's goal, ONC tracks physician adoption of EHRs. Data from FY 2005 established a baseline of 10 percent of physicians adopting EHRs. The target for FY 2006 was 14 percent of physicians adopting EHRs, but no survey was conducted that year, and consequently, no data is available. For FY 2007, data shows that 14 percent of physicians have adopted EHRs. ONC is identifying and analyzing the factors that pose barriers for physicians to adopt EHRs. By FY 2009, ONC expects that the physician adoption rate will increase to 30 percent.

Actions of other HHS entities that collaborate with ONC could affect the physician adoption rate. For instance, the CMS EHR demonstration could affect the adoption rate among small to medium-sized practices. Also, beginning in FY 2009, programs that promote the workforce development for health IT products and educate the public on health IT may positively influence adoption rates.



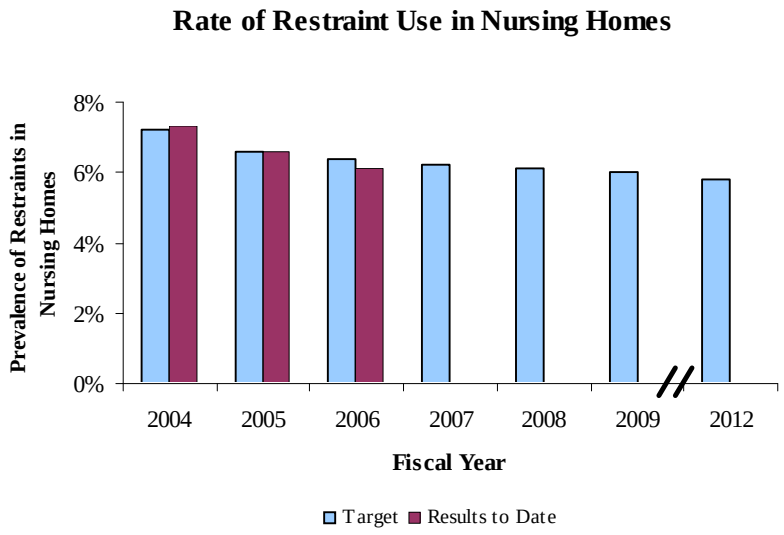
ONC faces programmatic and management challenges in addressing the multiple barriers that physicians confront in transitioning from paper to electronic medical records. ONC is coordinating with its Federal partners to address these challenges. For instance, ONC and its Federal partners are working to eliminate legal barriers that Stark and anti-kickback laws pose that prevent hospitals from financially contributing towards a physician's purchase of certified EHRs. In addition, ONC is ensuring that certification of health IT products includes the criteria necessary for interoperability to encourage physicians to buy certified EHRs. ONC is also working with malpractice insurers to potentially lower malpractice insurance premiums for physicians who have adopted certified EHRs.

Data Source: This final data is obtained from the Centers for Disease Control and Prevention (CDC) National Ambulatory Medical Care Survey. FY 2008 data will be available in February 2009.

<u>Performance Measure</u>: Decrease the prevalence of restraints in nursing homes.

Description: Medicare finances health insurance for eligible elderly and disabled individuals. The Centers for Medicare & Medicaid Services' (CMS) Nursing Home Quality Initiative is a broad-based effort that includes continuing regulatory and enforcement systems. In addition, community-based nursing home quality improvement programs, and partnerships and collaborative efforts to promote awareness and support, are underway.

Performance: "Physical restraints" are defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to a nursing home resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body. The prevalence of physical restraints is an accepted indicator of quality of care in nursing homes and the reduction in their use has been the focus of one of CMS' major quality initiatives, through CMS annual survey and the efforts of the Quality Improvement Organizations (QIOs), which work directly with individual providers to improve quality of care. As a result, the prevalence of physical restraints in nursing homes has decreased steadily since FY 1996, although their use continues to decline at a slower rate.



CMS performance was better than its FY 2006 target for prevalence of restraints in nursing homes of 6.4 percent by 0.3 percentage points. Although this was a decrease of 0.5 percentage points from the FY 2005 rate, this was a smaller decrease than in previous fiscal years. The slower rate of decline in the prevalence of physical restraints in nursing homes reflects the fact that many nursing homes have achieved low restraint rates. Those that have not will require particularly energetic interventions to reduce the use of physical restraints. CMS Regional Offices work to help State Agencies improve the survey process and to reduce restraint use. QIO focus on restraint use in nursing homes will also help to lower this rate. CMS will continue to monitor and evaluate performance to see if trends continue and will adjust strategies, activities and targets as needed in the future.

Data Source: The data for this measure is from CMS' Minimum Data Set-Quality. There is a data lag such that results for FY 2007 will not be available until February 2008.

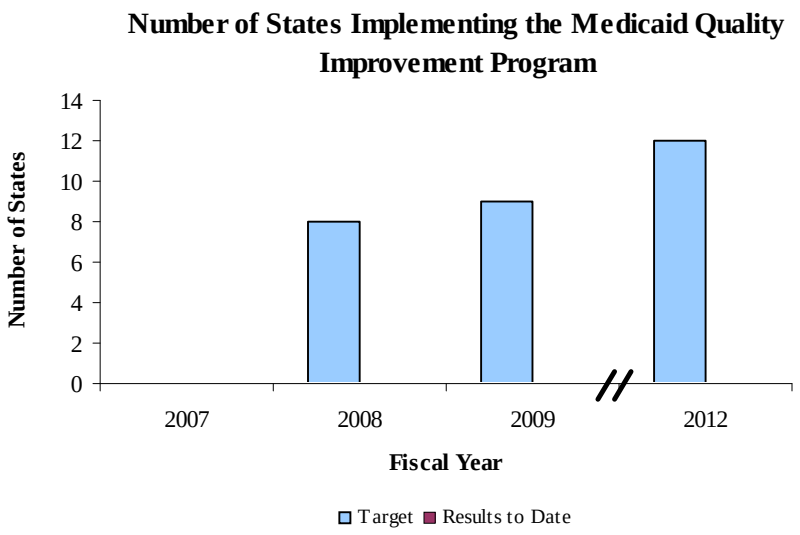
<u>Performance Measure</u>: Increase the number of States that have the ability to assess improvements in access and quality of health care through implementation of the Medicaid Quality Strategy.

Description: Medicaid is a means-tested health care entitlement program jointly financed by States and the Federal Government that provides medical assistance on behalf of families with dependent children, pregnant women, children, and aged, blind and disabled individuals.

Performance: The Medicaid Quality Improvement Program supports States in achieving safe, effective, efficient, timely, equitable, and patient-centered care. This long-term measure tracks the number of States participating in the program. In FY 2007, the baseline year (zero States), the Centers for Medicare & Medicaid Services (CMS) began a thorough review of data sources and data collection tools to document State quality activity. Information packets were developed for dissemination to States for both informational purposes and validation of State quality activities.

The FY 2008 target is to have 15 percent (eight States) participating in the Medicaid Quality Improvement Program. The National Association of State Medicaid Directors (NASMD) formally launched the development of the National Quality Framework for Medicaid indicating the agreement of all States to participate in achieving the Program's goals. The first State quality assessment, the primary vehicle for improving States' ability to assess quality and access to care, was initiated in early 2008. CMS will initiate assessments with at least seven more States during FY 2008. The FY 2009 target is to have 18 percent (nine States) participating in the program, with 24 percent (12 States) participating in the program by FY 2012.

The primary challenge in meeting these targets is that State participation is voluntary. Nonetheless, States recognize that participation in the development of a National Quality Framework for Medicaid presents important opportunities for improvement. States are looking to CMS for guidance in achieving improved outcomes for their Medicaid beneficiaries and programs. Engaging with representative groups such as NASMD and the National Medicaid Medical Directors Network, CMS is able to garner support from stakeholders and champions for State participation.

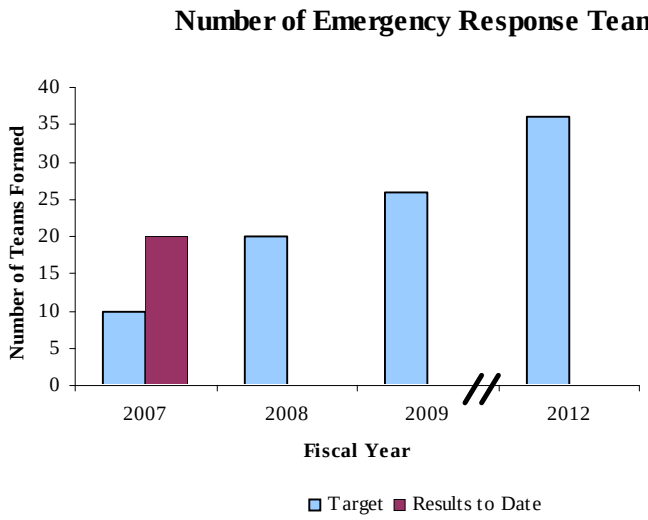


Data Source: The data for this measure is from State reports, including but not limited to State Quality Improvement Strategies, External Quality Review Organization Reports, and Home- and Community-Based Services Waiver Quality Assessment reports. There is a six month data lag.

<u>Performance Measure</u>: Increase the number of Commissioned Corps response teams formed.

Description: The United States Public Health Service Commissioned Corps (one of the seven Uniformed Services of the United States) protects, promotes, and advances the health and safety of the Nation. The Commissioned Corps is the primary asset for HHS to effectively respond to bioterrorism and other public health challenges. Better coordination of Corps officers in the field is necessary for effective emergency response.

Performance: In order to protect the health of the American people, HHS is dedicated to transforming the Commissioned Corps into a force that is ready to respond to public health challenges and health care crises. As a result of Katrina Lessons Learned report, HHS determined the need for and number of fully trained response teams. In FY 2007, HHS established a model for operational preparedness of the Corps. The new response structure consists of an increased number of organized and fully functional teams. These response teams vary in size based on function and response needs. Twenty response teams have been created, are fully trained, have adequate logistical support, and can deploy in the field when needed. This exceeds the FY 2007 target of 10 teams. The Corps was able to exceed this goal as result of a one time allocation of funds for rapid deployment force training. In light of the FY 2008 enacted funding level, the 20 fully equipped teams will be maintained and no new teams formed. The FY 2009 budget request reflects the funding required to reach the target of 26 fully trained teams.

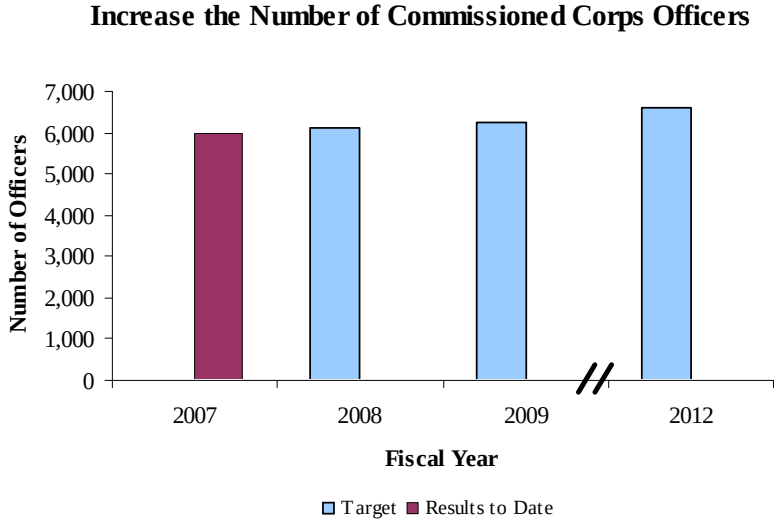


Data Source: The data for this measure is from the Office of the Surgeon General, Office of Force Readiness and Deployment.

<u>Performance Measure</u>: Increase the number of Commissioned Corps Officers.

Description: The United States Public Health Service Commissioned Corps (one of the seven Uniformed Services of the United States) protects, promotes, and advances the health and safety of the Nation. The Commissioned Corps is the primary asset for HHS to effectively respond to bioterrorism and other public health challenges. Individual officers work day-to-day in HHS and other agencies and are available to deploy to areas in need as determined by HHS.

Performance: As a result of numerous public health emergencies, in 2006 HHS established a goal to expand the Commissioned Corps by 10 percent to 6,600 officers. To accomplish this goal, the Commissioned Corps began an initiative in FY 2007 (baseline year) to increase the size of the Corps to 6,600 officers by 2012. Reaching this goal requires improvements in information technology infrastructure, training and education programs, and development of dedicated response elements within the Corps. Targets from FY 2009 – FY 2012 are consistent with the current funding requested.



Data Source: The data for this measure will be obtained from the Program Support Center Enterprise Application Division.

Strategic Goal 2: Public Health Promotion and Protection, Disease Prevention, and Emergency Preparedness

Prevent and control disease, injury, illness, and disability across the lifespan, and protect the public from infectious, occupational, environmental, and terrorist threats.

The four broad objectives under Public Health Promotion and Protection, Disease Prevention, and Emergency Preparedness are:

- Objective 2.1: Prevent the spread of infectious diseases;
- Objective 2.2: Protect the public against injuries and environmental threats;
- Objective 2.3: Promote and encourage preventive health care, including mental health, lifelong health behaviors, and recovery; and
- Objective 2.4: Prepare for and respond to natural and man-made disasters.

Throughout the 20th century, advances in public health and medicine resulted in reduced mortality and morbidity from infectious diseases. Chronic diseases, such as heart disease, stroke, cancer, and diabetes replaced infectious diseases as the major cause of illness and death in the United States in the latter part of the 20th century. As HHS works to address chronic diseases, infectious diseases have reemerged as a priority for public health in the United States. For example, risky behaviors such as unprotected sex and injection drug use continue to result in new HIV/AIDS infections. The proportion of persons with HIV infections diagnosed before progression to AIDS declined slightly from 78.1 percent in 2002 to 76.5 percent in 2005. The percentage of individuals age 12 and over whom report having used an illicit drug within the previous 30 days remained stable from 2002. However, among adolescents ages 12 to 17, the rate of use fell from 11.6 percent to 9.8 percent, in FY 2006.

Foodborne diseases cause an estimated 76 million illnesses, 325,000 hospitalizations, and 5,000 deaths in the United States each year. On December 11, 2007, Secretary Leavitt signed two Memoranda of Agreement between HHS and two Chinese government agencies to improve the safety of food, feed, drugs, and medical devices. Chinese regulators will certify that food, feed, and medical products covered by the agreement meet FDA standards. Inspectors from FDA will also gain broader access to Chinese production facilities and on an expedited basis.Vaccinations protect individuals, and through herd immunity, vaccinations also protect communities. Ninety percent coverage for early childhood immunizations was met in FY 2006 for most vaccines with the exception of varicella, pneumococcal conjugate vaccine, and the fourth dose of Diphtheria-Tetanus-Pertussis.

Public health emergencies have become a significant focus for public health at the Federal, State and local levels. The Strategic National Stockpile (SNS) permits HHS to respond to mass trauma events by delivering medical supplies to any point in the United States within 12 hours. At the end of FY 2007, 78 percent (42/54) of the States and directly-funded cities demonstrated preparedness to use SNS assets, not reaching the 90 percent target. The primary challenge for this program continues to be recruitment, and training of staff and volunteers to execute a mass prophylaxis plan due to the number of competing priorities and initiatives at the State and local level.

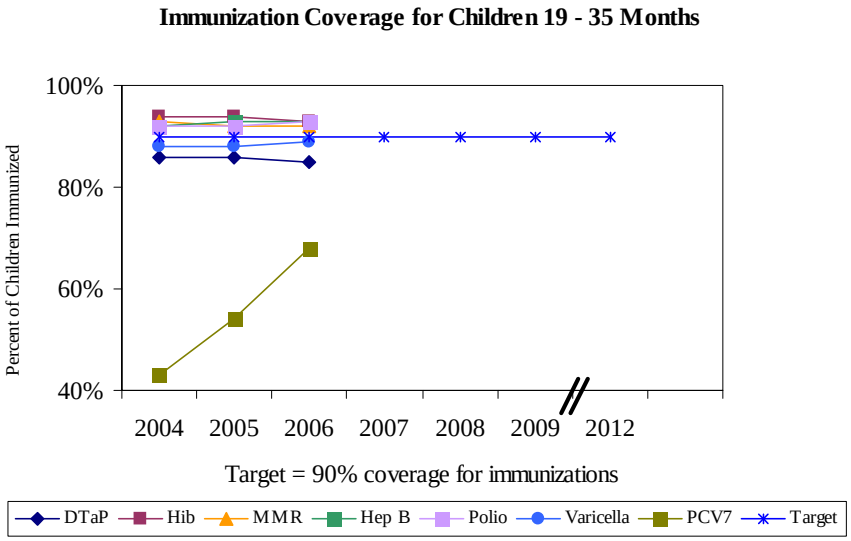
The table below shows HHS' progress in meeting targets for Strategic Plan measures for Strategic Goal 2 in this document.

Fiscal Year	Total Targets	Targets with Results Reported			
		Number with Results	%	Number Met	%
2004	13	13	100%	9	69%
2005	13	13	100%	8	62%
2006	19	14	74%	8	57%
2007	21	11	52%	3	27%

<u>Performance Measure</u>: Achieve or sustain immunization coverage of at least 90% in children 19 to 35 months of age for: a) 4 doses of Diphtheria-Tetanus-Pertussis (DtaP) vaccine; b) 3 doses of polio vaccine; c) 1 dose of Measles-Mumps-Rubella (MMR) vaccine; d) 3 doses of hepatitis B vaccine; e) 3 doses of Haemophilus influenzae type b (Hib) vaccine; f) 1 dose of varicella vaccine; and g) 4 doses of pneumococcal conjugate vaccine (PCV7).

Description: The Childhood Immunization Program through Centers for Disease Control and Prevention (CDC) aims to prevent disease, disability and death in children and adults through vaccination by providing grants to State and local health departments to purchase vaccines and conduct immunization programs.

Performance: Vaccinations protect individuals, and through "herd immunity," vaccinations also protect communities. Maintenance of high vaccination coverage levels in early childhood is the best way to prevent the spread of vaccine preventable diseases. In general, vaccination coverage levels of 90 percent are sufficient to prevent circulation of viruses and bacteria-causing diseases. Ninety percent coverage was met in FY 2006 for most vaccines with the exception of varicella, PCV7, and the fourth dose of DTaP. Varicella has almost reached the target; rates have risen from 43 percent in FY 1998 to 89 percent in FY 2006. Because antibiotic resistance is making pneumococcal infections difficult to treat, the prevention of pneumococcal infections with PCV7 i s becoming more important. Vaccination coverage with four doses of PCV7 is reported for the first time in 2006 at 68 percent; coverage rates in the first reporting year below the 90 percent target are not uncommon. Reaching 90 percent coverage for the fourth dose of the DTaP vaccine has also been difficult to achieve because the fourth dose vaccine requires a specific visit to the doctor and does not coincide with regular well-baby visits as the first three doses do.



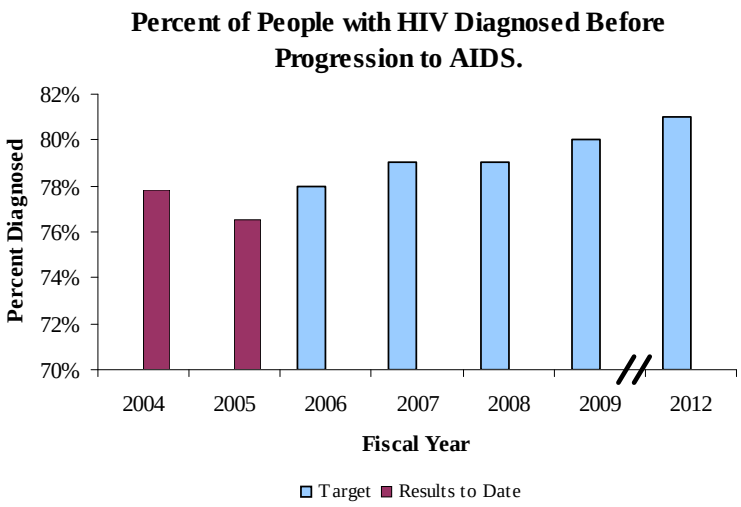
Routine childhood vaccination as part of the childhood immunization schedule prevents nearly 14 million disease cases and 33,000 deaths over the lifetime of children born in any given year and has resulted in annual savings of $9.9 billion in direct medical costs and an additional $33.4 billion in indirect savings. Each year, the program must both ensure the vaccination of newly-born children and ensure that all children are vaccinated for any new vaccines added to the schedule. Nearly one million two-year olds in the U.S. have not received one or more of the recommended vaccines. Coverage levels for immunized children by age two are high nationally. In many States, however, pockets of need, or areas where substantial numbers of under-immunized children reside, challenges continue and coverage in these areas is below the 90 percent target.

Data Source: The data for this measure is from the National Immunization Survey and has a one-year data lag.

<u>Performance Measure</u>: Increase the proportion of people with HIV diagnosed before progression to AIDS.

Description: To take advantage of more effective therapies and to prevent transmission of HIV to others, individuals should be aware of their HIV infection early in the course of the disease. The Centers for Disease Control and Prevention (CDC) provides funding and technical assistance to 65 State and local health departments to conduct HIV/AIDS prevention programs aimed at increasing early diagnosis.

Performance: Since the mid -1990s, effective medical therapies for both HIV infections and associated infections that develop because of weakened immune systems have dramatically reduced death rates associated with HIV. Age-adjusted mortality due to HIV disease declined from approximately 17 per 100,000 population in 1995 to less than six per 100,000 population in 2002. Because people with HIV are living longer, there are more opportunities for those diagnosed with HIV to take advantage of effective therapies prior to HIV progressing to AIDS.



In FY 2005, the most recent year for which data are available, the proportion of persons with HIV infection diagnosed before progression to AIDS decreased slightly from the previous year, to 76.5 percent. This data is not an isolated result. The proportion of persons with HIV infections diagnosed before progression to AIDS declined slightly from 78.1 percent in 2002 to 77.8 percent in 2004. Targets for this measure begin in FY 2006, and CDC will use future data to measure its progress toward its HIV/AIDS prevention goals.

About one quarter of persons in the U.S. infected with HIV do not know they are infected. Denial about HIV may be one reason why HIV-infected individuals do not get tested. Issues such as substance abuse (including injection drug use), mental health problems, childhood sexual abuse, and other psychological stressors may make it difficult for people to protect themselves and their partners. In addition, persons with HIV have historically had less access to medical care and have a higher rate of conditions, such as gonorrhea and syphilis, known to elevate risk of HIV transmission. Finally, the stigma related to an HIV diagnosis may cause people to avoid getting tested for HIV or to avoid medical care because their HIV infection may become known and lead to rejection by family members, friends, and coworkers.

CDC continues to promote early diagnosis through HIV testing and screening. The agency issued revised recommendations for HIV testing in medical care settings in 2006 and, in 2007, funded an initiative to promote increased testing in jurisdictions with the highest rates of disease among African Americans. In 2008 and 2009, CDC will continue to work with insurers and medical care providers to increase the uptake of its HIV screening recommendations. Funding increases proposed in the FY 2009 President's Budget will support expanded testing programs in jurisdictions with the greatest rates of new infections. In addition, funding will support grants to States with specific opt-out testing laws and policies for targeted populations.

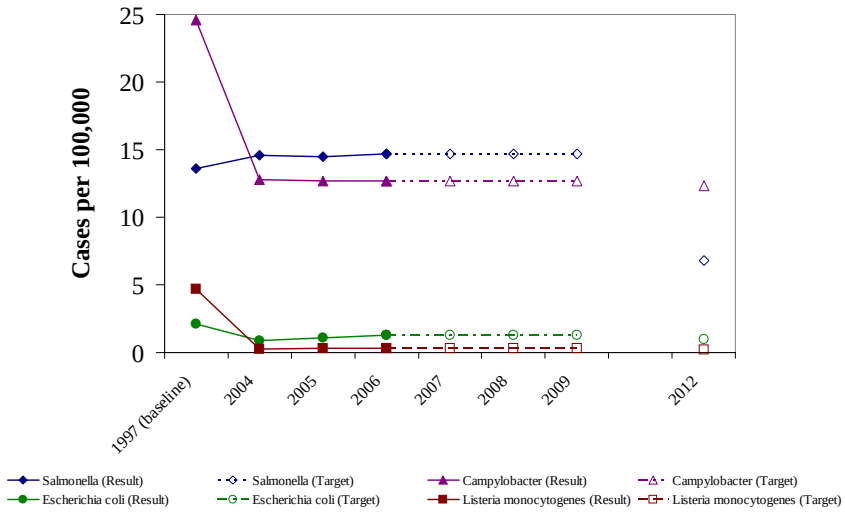
Data Source: Data for this measure is from the HIV/AIDS Reporting System and has a two-year data lag.

Performance Measure: Reduce the incidence of infection with key foodborne pathogens.

Description: HHS supports activities to reduce or prevent the incidence of foodborne illness associated with key foodborne pathogens. Data from the Foodborne Diseases Active Surveillance Network (FoodNet) show that the preventive measures being implemented by the Food and Drug Administration (FDA), the Food Safety and Inspection Service (FSIS) of the U.S. Department of Agriculture, and others are achieving significant public health outcomes in the effort to reduce the incidence of foodborne illness.

Performance: Federal, Tribal, and State partners have used research, inspections, surveillance, standardization and education as strategies to improve food safety. Food borne illness surveillance information is used to determine what additional food safety strategies are needed and to measure the effectiveness of interventions over time. This goal was originally developed with a single long term target, so interim targets before FY 2007 are not available. Incidence of illnesses caused by *Campylobacte*r species dropped from 24.6 cases per 100,000 to 12.7, *E. coli* O157:H7 dropped from 2.1 to 1.3, and *Listeria monocytogenes* decreased 0.47 to 0.31 between FY 1997 and FY 2006, with all approaching the 50 percent reduction goal. Attribution information for pathogens and foods is useful to focus future prevention and intervention efforts. Further investigation is needed to identify sources for emerging *Salmonella* serotypes, since the rate of infection has increased in the past decade.

Reduce the Incidence of Infection with Key Foodborne Pathogens



The Nation's challenges to food protection are increasing as consumers buy foods from around the globe. FDA's new *Food Protection Plan* features a scientific and risk-based approach of prevention, intervention, and response to ensure the safety of domestic as well as imported foods. The *Food Protection Plan* supports FDA's ongoing collaborations, outlines specific actions, and requests legislative authorities to strengthen FDA's ability to prevent foodborne illnesses.

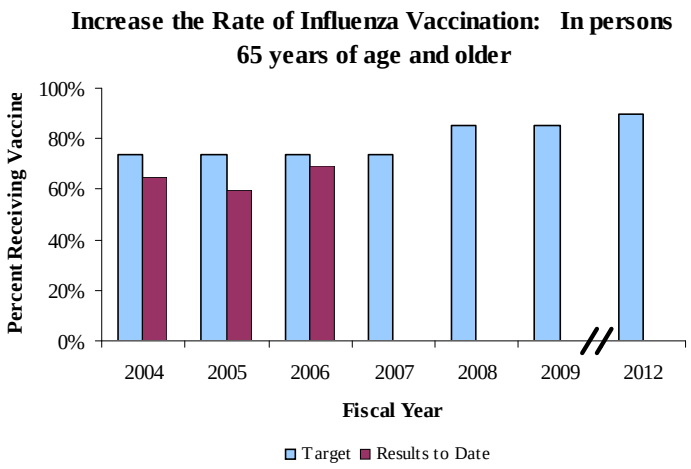
Data Source: The data for this measure is FoodNet (the Foodborne Diseases Active Surveillance Network) and the Healthy People 2010 Food Safety Progress Review. This measure has a one year data lag. The illnesses were chosen due to their incidence or severity, and because of the availability of tracking data through FoodNet.

<u>Performance Measure</u>: Increase the rate of influenza vaccination: a) In persons 65 years of age and older; and b) Among noninstitutionalized adults at high risk, aged 18 to 64.

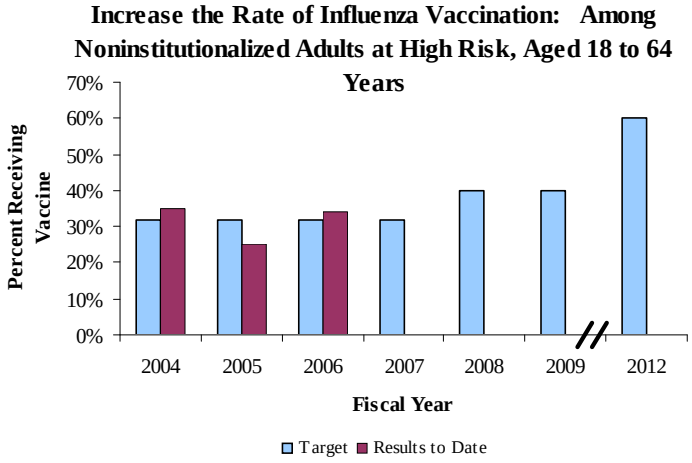
Description: The Centers for Disease Control and Prevention (CDC) has an immunization program that supports the Advisory Council for Immunization Practice's (ACIP) recommendations for influenza vaccination.

Performance: Vaccination coverage levels of 90 percent are sufficient to prevent circulation of viruses and bacteria-causing illnesses. Thus, a high percentage of a population at-risk for a vaccine-preventable illness should receive the vaccine. For adults at high risk for influenza, the ACIP Recommended Adult Immunization Schedule recommends annual influenza and pneumococcal vaccination.

During the past decade, influenza vaccination coverage levels among older adults increased steadily as CDC implemented national strategies and promoted adult and adolescent immunization. However, in FY 2005, a decrease to coverage of 60 percent occurred, which was likely related to unprecedented shortages of influenza vaccination in the 2004-2005 season and delays of influenza vaccinations in the 2005-2006 seasons. In FY 2006, the most recent year for which data is available, influenza vaccination levels among the elderly increased to 69 percent. This increase is consistent with increases from 30 percent in FY 1989 to 65 percent in FY 2004. Due to an anticipated increase in vaccine promotion efforts among the elderly, CDC raised the FY 2008 and 2009 goals to 85 percent.



A decrease in influenza vaccine coverage was also seen in FY 2005 for the high-risk 18 to 64 year-old population. High-risk adults aged 18 to 64 years may not have insurance coverage for influenza vaccines, may make fewer visits for preventive care, and may not recognize influenza vaccination recommendations. Persons with high-risk conditions, such as heart disease and diabetes, remain at increased risk from these diseases.



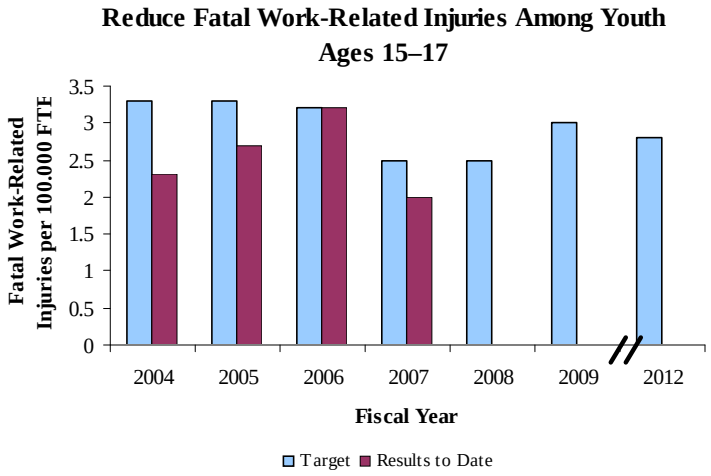
Adult vaccination rates are slowly increasing. CDC has worked with the Centers for Medicaid and Medicare Services to raise the reimbursement rate for healthcare providers for influenza vaccines. It is likely that issues with vaccine availability, distribution, and recognition of priority group recommendation affected coverage status. CDC will work with partner groups to increase awareness of influenza and pneumococcal vaccination recommendations.

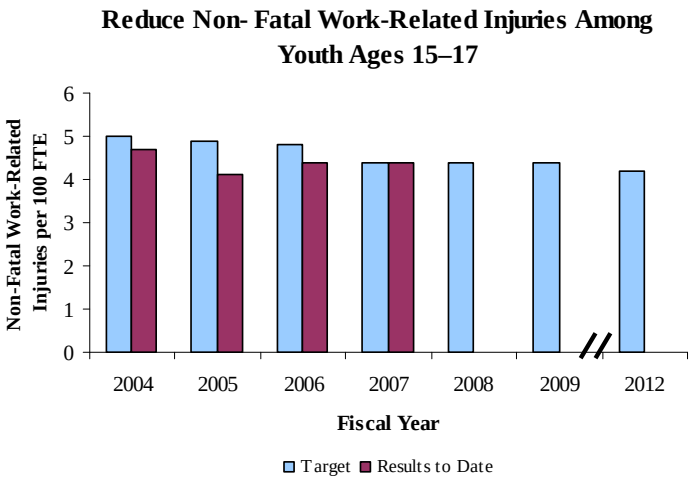
Data Source: The data for this measure is from the National Health Interview Survey. Data for FY 2007 will be available in January 2009.

<u>Performance Measure</u>: a) Reduce nonfatal work-related injuries among youth ages 15 to 17; and b) Reduce fatal work-related injuries among youth ages 15 to 17.

Description: The Occupational Safety and Health program through the Centers for Disease Control and Prevention (CDC) seeks to reduce young worker injuries primarily in the agricultural sector, which accounts for more work-related deaths of youth than any other industrial sector.

Performance: Rates of fatal and nonfatal injuries among young workers have steadily declined from the FY 2003 baseline of 5.2 fatal injuries per 100,000 full-time equivalent employees (FTE) and 3.5 non-fatal injuries per 100 FTEs. CDC has met or exceeded its targets for both nonfatal and fatal work-related injuries among youth for each of the subsequent years. In FY 2007, CDC met its target to reduce non-fatal injuries to 4.4 non-fatal injuries per 100 FTEs and exceeded its target to reduce fatal injuries to 2.5 fatal injuries per 100,000 FTEs with an actual reduction to 2 fatal injuries per 100,000 FTEs. These reductions in young worker injuries have been achieved through an increased awareness of the issue, recent changes in child labor laws, and recently finalized curricula that increase young workers' basic knowledge of workplace safety and health.





Despite the program's success, obstacles still remain to maintain a low rate of young worker injuries. Barriers to reducing young worker injuries include the minimal application of child labor laws in the high-risk agricultural injury sector and limited opportunities to introduce new work safety curricula into schools. CDC seeks to improve information translation to partners and other public health consumers. In FY 2009, CDC will work toward achieving a case rate of 4.4 non-fatal injuries per 100 FTE and 3 fatalities per 100,000 FTE. The FY 2009 target for fatal work-related injuries is higher than the actual FY 2007 result because targets were established based on the average rate of decline leading up to the 2003 baseline year. Additionally, fluctuations from year to year in the actual rates of fatal injuries may be a reflection of the relatively small number of fatal injuries that occur on an annual basis (30 to 50 injuries) where even a small change can significantly impact the number of fatal injuries per 100,000 FTE.

Data Source: The data for non-fatal injuries is from the National Electronic Injury Surveillance System. The data for fatal injuries is from the Census of Fatal Occupational Injuries special research file provided to National Institute of Occupational Safety and Health by Bureau of Labor Statistics.

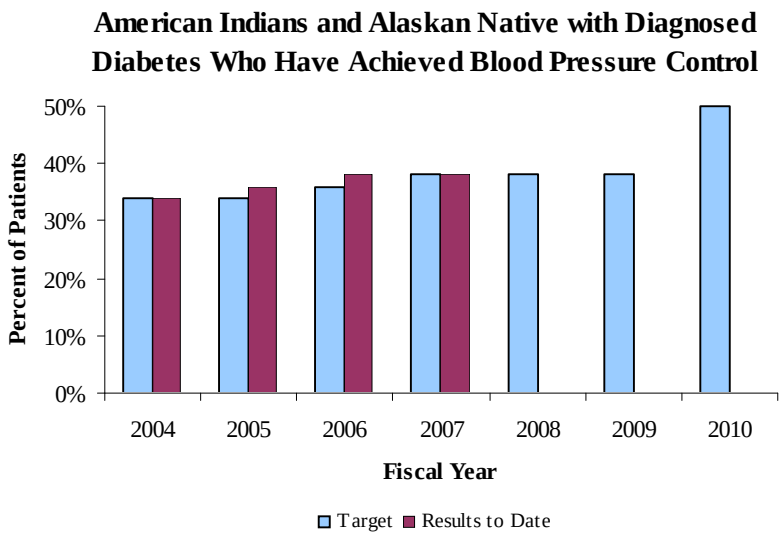
<u>Performance Measure</u>: Reduce complications of diabetes by increasing the proportion of American Indian/Alaska Native patients with diagnosed diabetes that have achieved blood pressure control (<130/80).

Description: The mission of the Indian Health Service (IHS) Division of Diabetes Treatment and Prevention Program is to develop, document, and sustain a public health effort to prevent and control diabetes in American Indians and Alaska Natives (AI/AN).

Performance: Controlling blood pressure among patients with diabetes is important in preventing complications associated with the disease. Nearly 75 percent of AI/AN with diabetes and aged 35 years or older also had hypertension in 2004. Lower blood pressure levels in those with diabetes reduces the risk of heart disease and stroke by 33-50 percent.

IHS met the FY 2007 target to maintain the FY 2006 performance level at 38 percent of patients with diabetes demonstrating blood pressure control for the Diabetes Audit. The program has met its targets for this measure since FY 2005.

The Division of Diabetes Treatment and Prevention Program faces many challenges in its efforts to ensure that patients have achieved blood pressure control. Blood pressure control in persons with diabetes generally results from blood pressure lowering medications and increased medical visits, in addition to healthy lifestyle practices. Large clinical trials have shown that blood pressure control may be more difficult to achieve in a person with diabetes and can often require 3-5 medications in combination to achieve acceptable blood pressure control. Despite the many blood pressure lowering medications on the market, the newer, more effective agents are expensive. Consequently, many AI/AN patients are unable to achieve the full benefit of blood pressure control otherwise attainable with the availability of these medications. Even with the difficulty of achieving ideal blood pressure control in people with diabetes, the program has continued to meet its annual targets. The target for FY 2009 is to maintain the FY 2008 level of performance.



Data Source: IHS tracks this measure using their Annual Diabetes Care and Outcomes Audit. Participation in the Audit is required for IHS facilities and voluntary for tribal diabetes programs (although strongly encouraged). Special Diabetes Program for Indians grantees are required to participate in the audit. The validity and reliability of its statistical data are maximized by uniform data collection and reporting procedures.

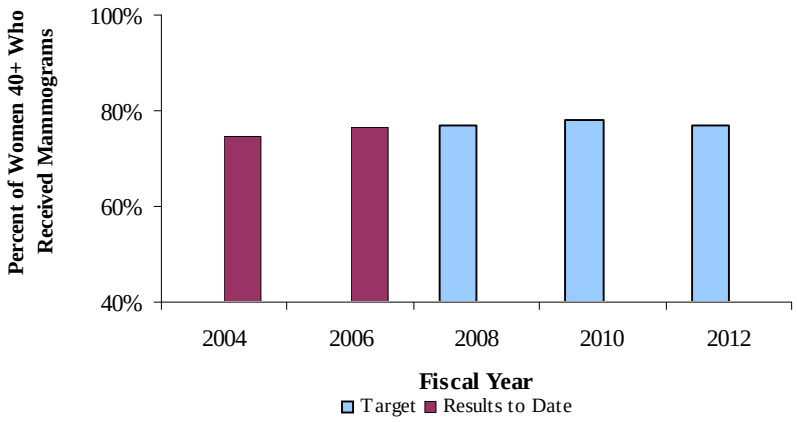
<u>Performance Measure</u>: Increase the proportion of women aged 40 years and older who have received a mammogram within the preceding 2 years.

Description: CDC's National Breast and Cervical Cancer Early Detection Program (NBCCEDP) provides free or low-cost breast and cervical cancer screening and diagnosis to low-income, uninsured, and underinsured women.

Performance: Timely mammography screening among women aged 40 years or older is the best available method to detect breast cancer in its earliest, most treatable stage, and could reduce breast cancer mortality by approximately 16 to 30 percent compared with women who are not screened. In FY 2004, the baseline year for this measure, the percentage of women 40 years or older who received a mammogram within the prior two years was 74.6 percent.[(1)] In FY 2006, the most recent year for which data are available, the percentage of women who received mammograms increased to 76.6 percent, demonstrating considerable progress toward achieving the FY 2008 target of 77 percent.

The national screening program has contributed to the notable decline, in recent years, in breast and cervical cancer deaths by providing access to screening services, increasing breast and cervical cancer awareness and education, and inherently changing health-seeking behaviors in women for whom screening services are not otherwise available or accessible.

Proportion of Women Aged 40 Years and Older Who Have Received a Mammogram within the Preceding 2 Years.



Nationwide cancer screening measures, including mammography, vary for a number of reasons, such as publication of national guidelines, Medicare benefits, the passage of State legislation on private insurance coverage, physician recommendations, cancer awareness and education, general health-seeking behaviors, and other social and economic factors, such as access and affordability. CDC provides services only to low-income, uninsured, and underinsured women. The program is able to reach 15 percent of eligible women 40 years or older. In 2006, the NBCCEDP screened 380,719 women for breast cancer. This was about one-half of one percent of the total population of women age 40 years or older in the United States.

CDC aims to increase the percentage of mammograms in women 40 years or older to 78 percent in FY 2010. Based on increasing annual rates in the 1990s, and the recent slowing of these increases in mammography use since the late 1990s, these projected increases will be challenging, yet achievable.

Data Source and Reliability: The data for this measure is from the Behavioral Risk Factor Surveillance System and is collected every other year.

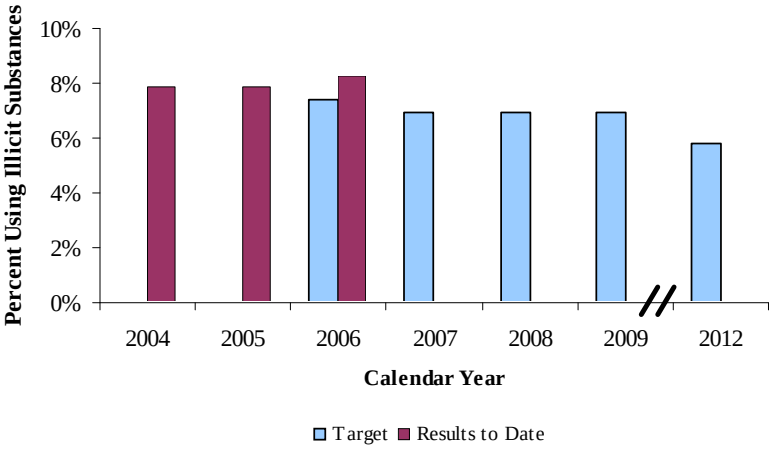
[1] CDC does not report in odd years, as data for this measure is in the Women's Health section of the Behavioral Risk Factor Surveillance System, which is an optional "Module" in odd years.

Performance Measure: Reduce 30 - day use of illicit substances (age 12 and older).

Description: The Substance Abuse and Mental Health Services Administration (SAMHSA) awards Strategic Prevention Framework grants to build the capacity of States, Tribes, Territories, and communities to decrease substance use and abuse and promote behavioral health. SAMHSA also administers a formula grant to States and numerous other activities targeted at reducing substance use and its associated consequences.

Performance: The percentage of individuals age 12 and over who report having used an illicit drug within the previous 30 days remained stable from 2002 (8.3 percent) to 2006 (8.3 percent), the most recent year for which data is available. The 2006 target of 7.4 percent was not met, as national substance abuse rates are influenced by many factors, including the emergence of new drugs of abuse and demographic and economic trends. However, among adolescents ages 12 to 17, the rate of use fell from 11.6 percent to 9.8 percent, reflecting the success of prevention efforts such as the SAMHSA Strategic Prevention Framework.

30 day Use of Illicit Substances (Age 12 and Older).



In 2007 HHS established the ambitious goal of reducing the rate of illicit drug use to 5.8 percent by 2012. In order to achieve this goal, a target has been established to reduce illicit drug use to 6.9 percent by 2009.

In pursuit of continual reductions in illicit drug use, SAMHSA has implemented an automated data collection and reporting system that will provide administrators, policy-makers, and practitioners with feedback on their prevention efforts, enabling them to modify their initiatives to address realities on the ground.

Data Source: The data for this measure is from the SAMHSA National Survey on Drug Use and Health, which has a one year data lag.

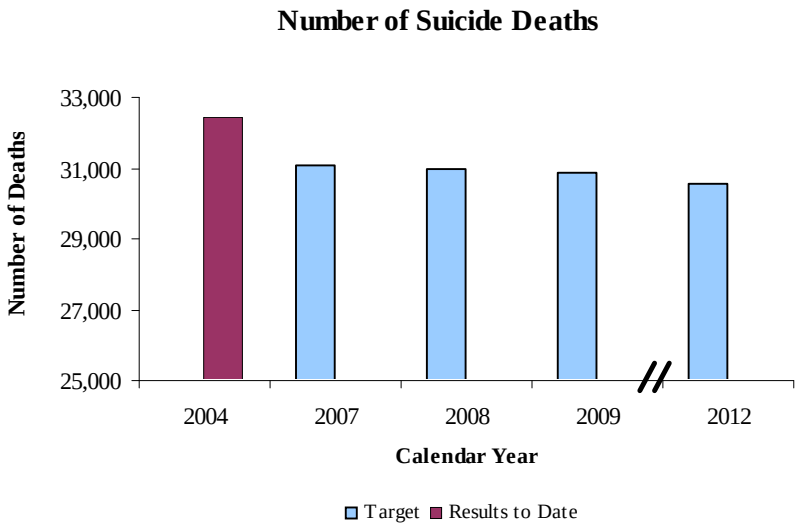
<u>Performance Measure</u>: Reduce the number of suicide deaths.

Description: The Substance Abuse and Mental Health Services Administration (SAMHSA) administers suicide prevention grants to campus, State, and Tribal organizations as authorized by the Garrett Lee Smith Memorial Act; a Suicide Prevention Hotline; a Suicide Prevention Resource Center; and an American Indian/Alaska Native Suicide Prevention initiative. Collectively, these efforts address the risk factors which contribute to suicide being the 11th leading cause of death in the United States.

Performance: The number of suicide deaths in the United States has steadily increased from 29,199 in 1999 to 32,439 in 2004. This represents an increase in the rate of suicide deaths from 10.5 to 11.0 per 100,000 people. In order to address this increasing trend, in 2007 HHS established the ambitious goal of reducing suicide deaths by six percent by 2012.

Using 2004 as the baseline, the first annual target for this newly established performance measure is to reduce suicide deaths from 32,439 to 31,084 in 2007. Results for 2007 will be available in 2010, after the requisite data has been compiled from death certificates filed with State vital-statistics offices.

To reduce the number of suicide deaths each year, SAMHSA works through programs that focus on suicide prevention across the lifespan, as well as through programs focused on youth suicide prevention. The Suicide Prevention Resource Center provides prevention support, training, and resources to assist organizations and individuals to develop suicide prevention programs, interventions and policies. The National Suicide Prevention Lifeline provides 24-hour, toll-free telephone access to a network of certified local crisis centers available to anyone in suicidal crisis.



To address youth suicide, SAMHSA will continue to support grants to States, Tribal organizations, and institutions of higher education to enhance services for students with mental and behavioral health problems that may lead to school failure, depression, substance abuse, and suicide attempts.

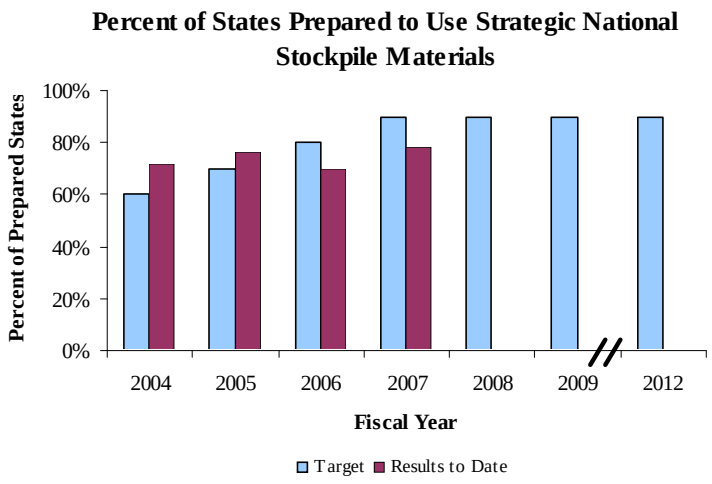
Data Source: This data is from CDC's National Vital Statistics Report, and has a three year data lag.

<u>Performance Measure</u>: Increase the percentage of State public health agencies prepared to use materiel contained in the Strategic National Stockpile (SNS).

Description: The Strategic National Stockpile (SNS) is a national repository of life saving pharmaceuticals, medical material, and equipment. The SNS permits HHS to respond to mass trauma events by delivering medical supplies to any point in the United States within 12 hours.

Performance: At the end of FY 2007, 78 percent (42/54) of the States and directly-funded cities demonstrated preparedness to use SNS assets, not reaching the 90 percent target. Through FY 2005, the results of the Centers for Disease Control and Prevention (CDC's) assessment of SNS preparedness exceeded performance targets. During FY 2006, the SNS program revised the standards used to assess SNS preparedness. In FY 2007 the program began conducting more rigorous assessments by requesting and analyzing additional data for each plan element that demonstrates preparedness. These efforts are intended to increase grantee preparedness to effectively manage and use deployed SNS materiel. Enhanced assessments, planning efforts, technical assistance, training, and exercises will contribute to improved performance during a public health emergency. At the end of FY 2007, 78 percent (42/54) of the States and directly-funded cities demonstrated preparedness to use SNS assets, not reaching the 90 percent target**.**

The primary challenge for this program continues to be recruitment, and training of staff and volunteers to execute a mass prophylaxis plan due to the number of competing priorities and initiatives at the State and local level. Some jurisdictions lack proper facilities to receive SNS materiel. Improved coordination between State and local agencies that are responsible for disaster preparedness is also a continuing challenge. Although more stringent standards and additional challenges may cause grantee status to fluctuate, the SNS program remains committed to the long term target of 100 percent of States and directly-funded cities that are prepared to use SNS materiel and the incremental targets to improve preparedness. The FY 2009 President's Budget includes an increase for the SNS program to finance the procurement of critical pharmaceuticals and vaccines needed to protect Americans from threat agents and support the capacity to deliver drugs, vaccines, and supplies anywhere in the Nation within 12 hours. Increased funds will help support the replacement of expiring product and increasing warehousing costs as the volume of the stockpile increases.



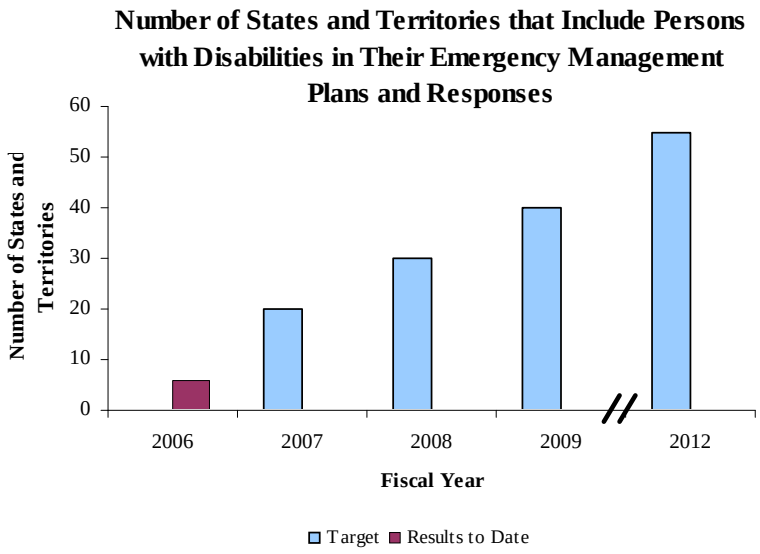
CDC, in collaboration with the National Association of County and City Health Officials and the Association of State and Territorial Health Officials is acting on findings in a recent survey by conducting regional meetings to collect, review, and share State and locally developed tools, templates, processes, plans, and other resources deemed by State and local public health, medical and emergency management experts as worthy of promoting as a national best practice. To assist with testing and validating State and local SNS plans, two modeling and simulation projects are also underway. Technical assistance and other resources for SNS preparedness information include listservs, satellite web casts, extranet sites, and SNS sponsored training courses.

Data Source: The data for this measure is from the 4th Quarter report on CDC evaluation of standard functions using SNS Assessment Tools, based on criteria outlined in *A Guide for Preparedness, V.10.00.*

<u>Performance Measure</u>: Increase the number of States and territories that include persons with disabilities in emergency management plans and responses.

Description: The Office on Disability (OD) represents HHS by chairing the New Freedom Initiative Emergency Response Health Subcommittee as part of the Department of Homeland Security (DHS) Interagency Coordinating Council (ICC) Workgroup to ensure emergency preparedness plans and responses at the Federal, State, Tribal, and community levels address the health and human services needs of persons with disabilities. Through collaboration with the Office of the Assistant Secretary for Preparedness and Response, OD developed an Emergency Responder Toolkit and the Shelter Intake Assessment Tool to assist States and territories in managing persons with disabilities in the event of an emergency.

Performance: An initial analysis performed by OD documented six States in FY 2006 that have emergency plans which include persons with disabilities. The FY 2007 target of 20 was not attainable due to a delay in developing and implementing the Emergency Responder Toolkit. The toolkit will be implemented by March 2008, and the OD will have the capability to measure in real-time the number of States that have added information regarding persons with disabilities to their emergency preparedness plans. With implementation of the toolkit the analysis will be enhanced and the FY 2008 target of 30 States will be met. By FY 2012 this toolkit will be implemented in all 55 States and territories.



In FY 2007 the National Red Cross used the OD Shelter Intake Assessment Tool, through a Memorandum of Understanding during the 2007 California wild fires. An analysis of the Assessment Tool is being conducted to determine the rate, ease of use and needed enhancements.

Data Source: The Annual Assessment Report of State Emergency Management Plans and Department of Homeland Security, Administration for Children and Families, Federal Emergency Management Agency, and Indian Health Services personnel. This measure has a data lag of one year.

Strategic Goal 3: Human Services

Promote the economic and social well-being of individuals, families and communities.

The four broad objectives under Human Services are:

- Objective 3.1: Promote the economic independence and social well-being of individuals and families across the lifespan;
- Objective 3.2: Protect the safety and foster the well-being of children and youth;
- Objective 3.3: Encourage the development of strong, healthy, and supportive communities; and
- Objective 3.4: Address the needs, strengths, and abilities of vulnerable populations.

Since welfare reforms were passed over a decade ago, the employment rates of current and former welfare recipients have risen and caseloads have diminished dramatically. Earnings for welfare recipients have increased, as have earnings for female-headed households. Additionally, child poverty rates have declined substantially since the start of the Temporary Assistance for Needy Families (TANF) program in 1997.

Despite these successes in prior years, HHS still had much work to do in FY 2007 to promote the economic and social well-being of individuals, families and communities. Self-sufficiency remains elusive for many individuals remaining on welfare; only one-third of adults in the TANF caseload met their work requirements in FY 2006. However, the job entry rate for FY 2006 was nearly 36 percent, exceeding the goal of 35 percent as well as the previous year's goal. This improvement is due to several factors, including the Administration for Children and Families' (ACF) commitment to finding innovative and effective employment tools through research, the identification and dissemination of information on the effects of alternative employment strategies, a range of targeted technical assistance efforts, and a strong economy.

The needs of vulnerable children continue to be a priority for HHS. There were 511,000 children in foster care in FY 2006, approximately ten percent of whom were adopted into safe and permanent homes. Preliminary data indicate that there were 51,000 adoptions in FY 2006, although this number is likely to increase as additional adoptions for FY 2006 are reported. At its current FY 2006 rate of adoptions, 9.91 percent, the program has already surpassed its FY 2006 target rate of 9.85 percent. The FY 2009 target for the adoption rate is 10.10 percent. As the American population ages, enhanced efforts are needed to help the growing number of older persons remain active and healthy. The need for long-term care services will also increase, and availability of home and community based services will be increasingly important to help people maintain their independence and quality of life.

People with disabilities, refugees and other migrants, and other vulnerable populations also need assistance and protection to achieve and sustain economic independence and self-sufficiency, as well as social well-being.

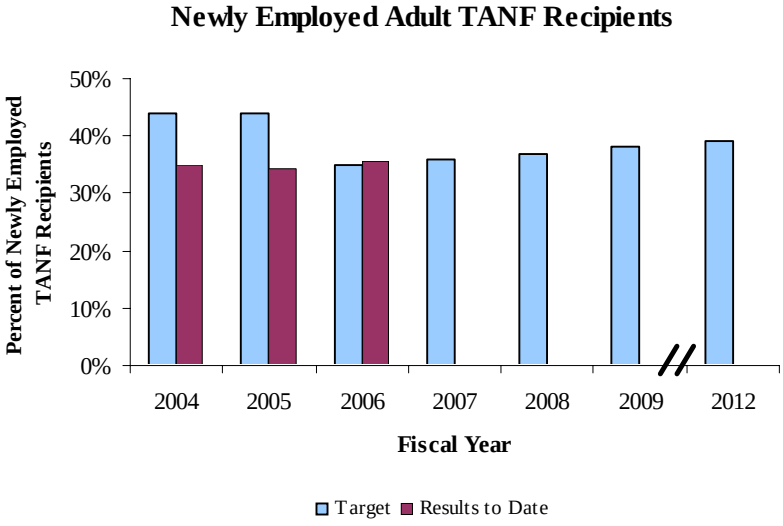
The table below shows HHS' progress in meeting targets for Strategic Plan measures for Strategic Goal 3 in this document.

Fiscal Year	Total Targets	Targets with Results Reported			
		Number	%	Number	%
2004	5	5	100%	2	40%
2005	7	7	100%	3	43%
2006	10	10	100%	5	50%
2007	10	2	20%	2	100%

<u>Performance Measure</u>: Increase the percentage of adult TANF recipients who become newly employed.

Description: The Temporary Assistance for Needy Families (TANF) program grants States Federal funds and wide flexibility to operate programs designed to: (1) provide assistance to needy families so that children may be cared for in their own homes; (2) end dependence of needy parents by promoting job preparation, work, and marriage; (3) prevent and reduce the incidence of out-of-wedlock pregnancies; and (4) encourage the formation and maintenance of two-parent families.

Performance: States have had success in moving TANF recipients to work, as evidenced by an increase in the job entry rate from 34 percent in FY 2003 to nearly 36 percent in FY 2006. This success means that more families are financially independent and not dependant on Federal and State assistance. Several factors contributed to this recent accomplishment, including the Administration for Children and Families' (ACF) commitment to finding innovative and effective employment tools through research, the identification and dissemination of information on the effects of alternative employment strategies, a range of targeted technical assistance efforts, and a strong economy.



Performance has been relatively level since FY 2004. The targets beyond FY 2003 reflect the implementation of the National Directory of New Hires (NDNH) as the single data source for this measure. Implementation of the NDNH significantly affected the data reported on job entry and increased reliability. Previously, States had to use their own data source and develop methods to collect, compile, and submit quarterly reports. Because the State-reported data differed significantly from the NDNH data reported for job entry, targets for FY 2006 and beyond were revised from a new baseline of 34 percent, established in FY 2003.

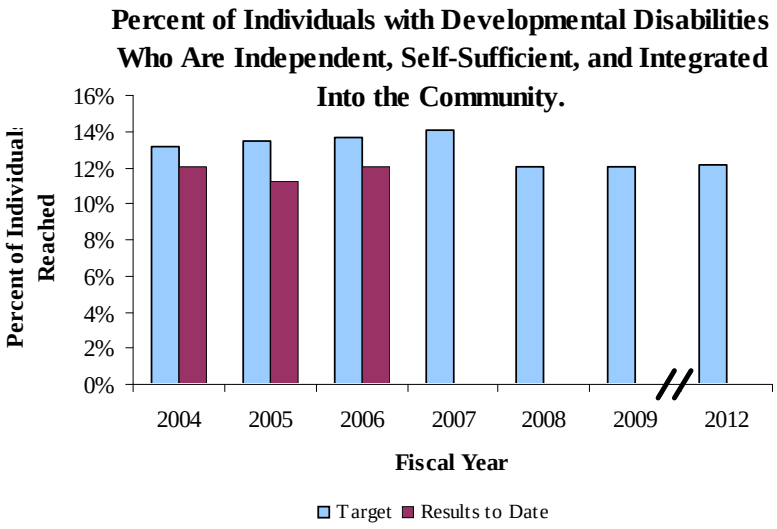
ACF faces several challenges in meeting its targets. The program is a block grant that gives States flexibility in serving clients, making it difficult for ACF to directly influence the number of adults entering employment. The measure also depends on factors not under ACF control, such as client skills, education, and State labor markets. However, the Deficit Reduction Act of 2005 (DRA) and the interim final DRA regulations signaled that States needed to renew efforts to move TANF recipients into work or face significant fiscal penalties. Because of more stringent work participation rates under DRA, ACF expects States to ensure that more recipients are engaged in work activities. In addition, the TANF DRA regulations defined each countable work activity for the first time, and the definitions ensure that all activities enhance job readiness. As a result, ACF expects that 38 percent of adult recipients will enter employment by FY 2009, and anticipates an increase to a rate of 39 percent by 2012.

Data Source: The data for this measure is obtained through the National Directory of New Hires (NDNH). Data are updated by States, and data validity is ensured with normal auditing functions for submitted data. This measure has a one-year data lag.

<u>Performance Measure</u>: Increase the percentage of individuals with developmental disabilities reached by State Councils on Developmental Disabilities who are independent, self-sufficient, and integrated into the community.

Description: The State Councils on Developmental Disabilities program assists each State in promoting the development of a comprehensive, statewide, consumer and family-centered system that provides a coordinated array of culturally-competent services and other assistance for individuals with developmental disabilities.

Performance: State Councils on Developmental Disabilities do not provide services directly, but rather review and analyze the quantity and quality of services provided at the State and local level to influence their effectiveness for individuals with developmental disabilities. The Administration on Developmental Disabilities (ADD) at the Administration for Children and Families administers this activity in partnership with the Councils. Inconsistencies in data quality, environmental factors such as the economy, and program funding have been obstacles to meeting targets in recent years. In FY 2004, the program missed its target of 13.20 percent, reporting an actual of 12.06 percent. In FY 2005, the actual dropped to 11.27 percent, missing the target of 13.64 percent. One strategy to improve performance has been working with States on data collection. ADD staff has identified outlier data on a State-by-State basis and worked with individuals States to make corrections. This oversight resulted in improved data quality.



In FY 2006, ADD (in partnership with the Councils) developed and published national standards for data definitions and provided training to Councils on their application. In FY 2006, this measure benefited from greater uniformity of reporting and the data increased over the previous year's performance to 12.05 percent, missing the target of 13.64 percent. Improvements to State service delivery systems are beginning to accelerate with improved outcomes for more individuals with developmental disabilities. By FY 2009, the program expects to increase the percentage by at least 0.10 percent each year over the previous year's result. By FY 2012, the program expects to achieve the long-term target of 12.12 percent.

A primary challenge for the Councils is improving measure standardization and quality. Progress is occurring through training and technical assistance on integration of strategic planning, reporting, evaluation and performance measurement, which should improve the efficiency and effectiveness of Council projects, activities and strategies.

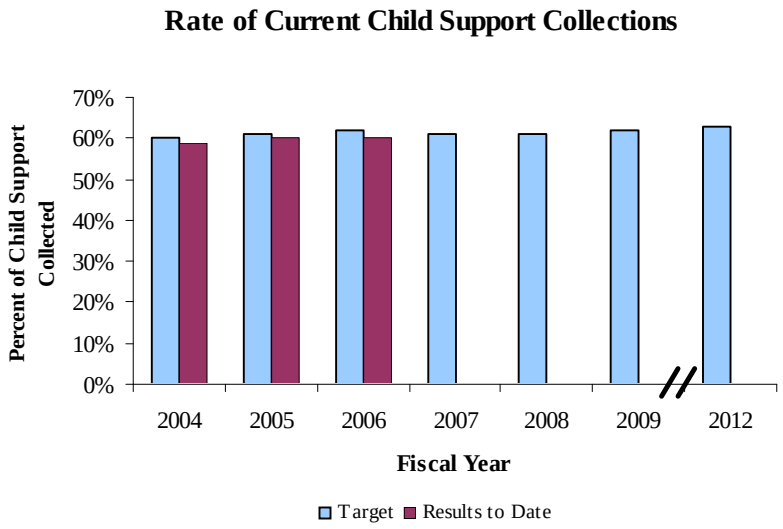
Data Source: The data for this measure is obtained through Program Performance Reports (PPRs) of State Councils. Outcome data are reported in annual PPRs, submitted in January of the following fiscal year through the On-Line Data Collection System. Verification and validation of data occur through ongoing review and analysis of annual electronic reports and technical assistance site visits.

<u>Performance Measure</u>: Increase the child support collection rate for current support orders.

Description: The Child Support Enforcement (CSE) program is a joint Federal, State, Tribal, and local partnership that seeks to ensure financial and emotional support for children from both parents by locating non-custodial parents, establishing paternity, and establishing and enforcing child support orders.

Performance: Child support collections play an important role for families transitioning from welfare to self-sufficiency. By securing support from non-custodial parents on a consistent basis, families may avoid the need for public assistance, thus reducing government spending. Since the creation of the CSE program, child support collections within the program have grown annually. States have increased collections by using a wide variety of approaches such as income withholding, offset of income tax refunds, and reporting to credit bureaus. In addition, new collection tools and program improvements, such as new hire reporting and increasing statewide automation, have increased collections and reliability of collections data and will continue to do so as these tools become fully implemented in all States.

The total amount of child support distributed as current support in FY 2006 was $18 billion (about a four percent increase over FY 2005) out of $30 billion in total current support due to families in that year. This translates into a current support collection rate of 60 percent, which is just below the target of 62 percent for FY 2006. The FY 2009 target for this measure is 62 percent. External factors make this targeted increase difficult to achieve. For example, as of FY 2008, the Deficit Reduction Act of 2005 (DRA) eliminates Federal match for State expenditure of incentive payments. The Office of Child Support Enforcement (OCSE) expects that while States will increase their State contributions to cover some of the lost Federal funds available for matching, they will not completely make up the shortfall and overall program expenditures will be reduced. Expenditures and collections are closely related in child support, and OCSE thus expects that this will result in a decreased rate of growth for child support collections compared to pre-DRA levels.



To overcome these challenges, OCSE will work to improve performance by focusing on new and improved enforcement techniques, such as the expanded passport denial program which is expected to result in increased collections. In addition, OCSE has launched a new national initiative in FY 2007 called PAID: Project to Avoid Increasing Delinquencies. This initiative places special emphasis on activities that increase current support collections and reduce arrearages.

Data Source: The data for this measure is obtained through the Office of Child Support Enforcement Form 157 at the Administration for Children and Families. This measure has a one-year data lag.

.Performance Measure: Increase the adoption rate for children involved in the Child Welfare System.

Description: Child Welfare programs prevent maltreatment of children, provide in-home services for at-risk children and families, find temporary foster placements for children who must be removed from their homes, and achieve safe and stable permanent placements for children.

Performance: The adoption rate measures the effectiveness of Federal child welfare and adoption programs. In FY 2005, Child Welfare programs replaced the measure of total adoptions with an adoption rate measure (annual number of children adopted during the year with public child welfare agency involvement divided by number of children in foster care at the end of the fiscal year for whom adoption is identified as the appropriate permanency plan). As such, there are no targets for this measure prior to FY 2006. A recalculation of existing data shows, however, that the adoption rate increased between FY 1996 and FY 2002. Although gains in this rate have slowed since then, each increase, no matter how small, means that more children who were unable to return to their own families exited care to stable, permanent adoptive homes.

Preliminary data indicate that there were 51,000 adoptions in FY 2006, although this number is likely to increase as additional adoptions for FY 2006 are reported. At its current FY 2006 rate of adoptions, 9.91 percent, the program has already surpassed its FY 2006 target rate of 9.85 percent. The FY 2009 target for the adoption rate is 10.10 percent. There are a number of external challenges that ACF will face in trying to meet these targets, including a decrease in the number of children in foster care and the fact that the age of children waiting to be adopted continues to increase. Almost half of the waiting children are over the age of nine. Simultaneously, the proportion of children in foster care with a case plan goal of adoption has declined.

Rate of Children Adopted from Child Welfare System

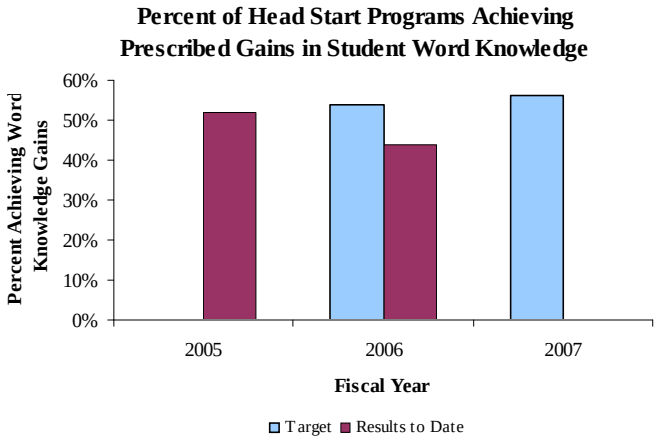
To overcome these challenges, the program launched a Spanish-language component of an existing national adoption Public Service Announcement campaign in December 2007 to reach out to a broader pool of prospective adoptive parents while promoting the adoption of children age nine and older. Nineteen percent of children waiting to be adopted are Hispanic. In FY 2008, the program also expects to have results from a four-year study of the barriers to completion of the adoption process. Lessons learned from this study will inform management decisions, as the program works to make the efforts even more effective. Finally, to provide greater adoption incentives to States, the FY 2009 Budget proposes to double the adoption bonus for children age nine and older.

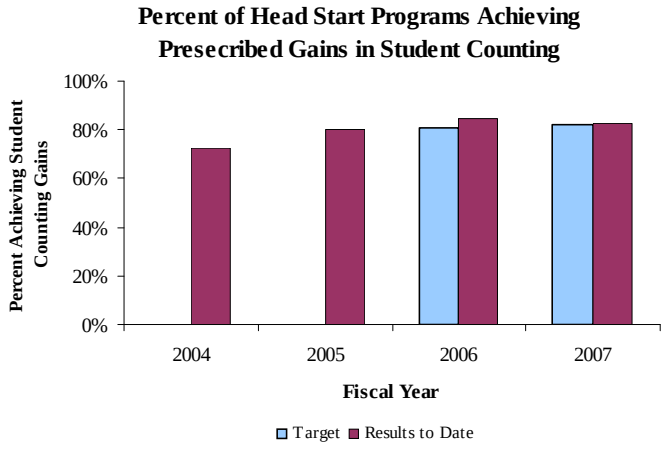
Data Source: The data for this measure is from ACF's Adoption and Foster Care Analysis Reporting System (AFCARS). AFCARS permits the reporting of adoptions finalized in one year to be reported in later years. Based on previous experience, it is likely with new AFCARS adoptions submissions and resubmissions from the States that the number of adoptions finalized in FY 2006 may increase by as many as one thousand adoptions. This measure has a one-year data lag.

<u>Performance Measure</u>: Increase the percentage of Head Start programs that achieve average fall to spring gains of: (a) At least 12 months in word knowledge (Peabody Picture Vocabulary Test); and (b) At least four counting items.

***Description*:** Head Start is a comprehensive child development program that serves young children under five, pregnant women, and their families. Its goal is to increase the school readiness of young children in low-income families.

Performance: Children's word knowledge and early numeracy skills have been shown to predict improved academic performance in school and are the precursors to learning to read, write, and do arithmetic. There is no FY 2004 data on word knowledge since Head Start programs established a new baseline in FY 2005, when 52 percent achieved the prescribed gains. FY 2006 data, the most recent available, showed that 44 percent of programs achieved the prescribed gains in word knowledge, falling short of the target of 54 percent. Across all programs, the average gain in vocabulary fell only by one month. Whereas programs gained, on average, at least 11 months in word knowledge, it was insufficient to meet the target, which only captures gains of twelve months or more.





In FY 2007, 82.7 percent of Head Start programs achieved the prescribed gains for counting items, which exceeded the target of 82 percent. This represents a slight decrease from the previous year's result of 84.6 percent, but shows significant improvement since the first year data was reported (FY 2004) at a rate of approximately 73 percent achievement.

Head Start consistently faces internal and external challenges that affect the performance trends for both of these measures. One internal challenge is program participation in assessments, as programs' degree of participation in the National Reporting System (NRS) fluctuated across years.

Because the Improving Head Start Act of 2007, which reauthorized the Head Start program, required the termination of the NRS, Head Start will only report data through FY 2007. Data for FY 2008 and later will not be collected or reported.

Data Source: The National Reporting System collected information on child outcomes, including progress in vocabulary, letter recognition, and mathematics, using consistent methodology across all programs. The NRS was operational in FY 2007, during the relevant period on which ACF is reporting. However, per the Improving Head Start Act of 2007, the NRS has been discontinued. When the study on the Developmental Outcomes and Assessments of Young Children by the National Academy of Science is completed, ACF plans to develop new measures for future years to replace those that rely on NRS data.

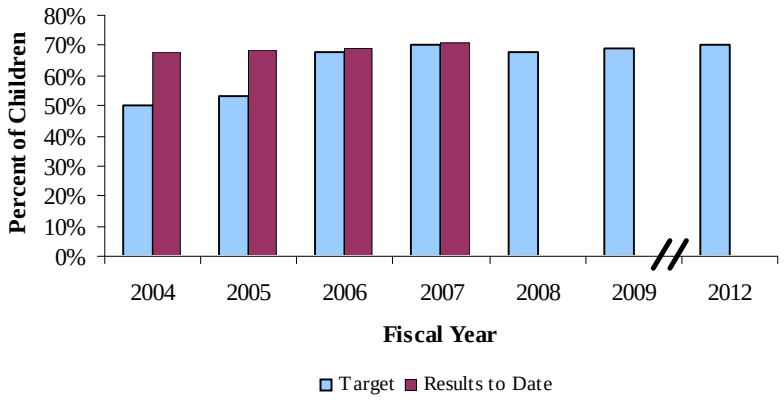
<u>Performance Measure</u>: Increase the percentage of children receiving Children's Mental Health Services who have no interaction with law enforcement in the 6 months after they begin receiving services.

Description: The Children's Mental Health Services program makes competitive grants to State and local governments to support community mental health services for children with serious emotional disturbance. Children receiving services through these grants experience improved behavioral outcomes, better school performance, and fewer disciplinary and law enforcement encounters.

Performance: The proportion of children with no interaction with law enforcement increased from 67.6 percent in FY 2004 to 69.3 percent in FY 2006, an indication of improved behavioral outcomes among program participants. Performance results for this measure are affected by the characteristics of grantees and the individual children served in a given year.

In FY 2007, 71.0 percent of children had no law enforcement contacts at six month follow-up, exceeding the target of 70.0 percent. The FY 2009 performance target is for 69.0 percent of participants to have no law enforcement contacts at six months. This target is lower than the FY 2007 target because many recent grant awardees focus on serving youth within the juvenile justice system, a population for which contacts with law enforcement are more common.

Percent of Children Served with No Law Enforcement Contacts



In pursuit of continued performance improvements, the Substance Abuse and Mental Health Services Administration (SAMHSA):

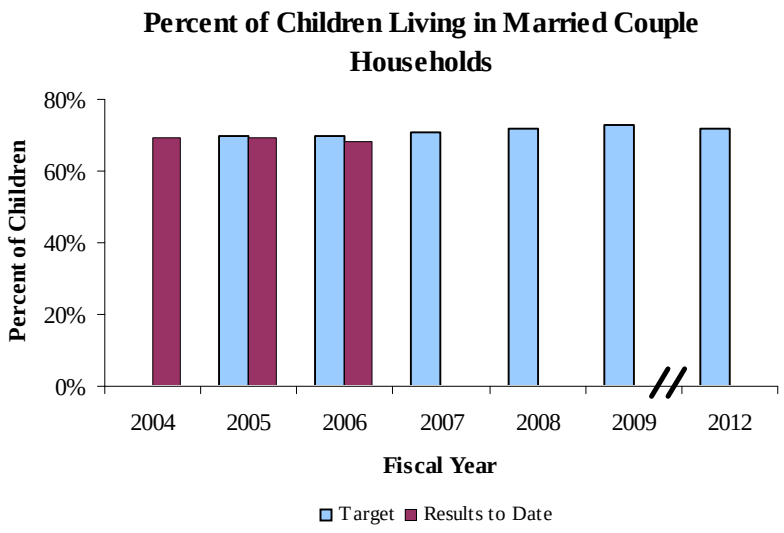
- Provides new grantees with "start up" technical assistance specifically designed to support grantee attainment of performance objectives;
- Conducts site visits to review and give feedback to grantees about their performance;
- Hosts grantee meetings focusing on specific themes related to achieving performance objectives;
- Develops and distributes printed materials related to performance objectives; and
- Connects grantees with specialists who have pertinent expertise.

Data Source: The data for this measure comes from the SAMHSA Delinquency Survey.

<u>Performance Measure</u>: Increase the number of children living in married couple households as a percentage of all children living in households.

Description: The Temporary Assistance for Needy Families (TANF) program grants States Federal funds and wide flexibility to operate programs designed to: (1) provide assistance to needy families so that children may be cared for in their own homes; (2) end dependence of needy parents by promoting job preparation, work, and marriage; (3) prevent and reduce the incidence of out-of-wedlock pregnancies; and (4) encourage the formation and maintenance of two-parent families.

Performance: The purpose of this measure is to evaluate the progress made regarding the program's goal of promoting healthy marriages. Research indicates that children who grow up in two-parent, married households have a more solid foundation for success than children who grow up in non-married households or without their father present. The most recent result for this measure was 68 percent in FY 2006, missing the target of 70 percent. This target increased by one percentage point from the previous year, which is quite rigorous given the measure's slow rate of change since 2002. The baseline for this measure, established in FY 2004, is 69 percent. The ability of the Administration for Children and Families (ACF) to affect performance on this measure has been limited; the movement in this measure has remained within a very narrow range since it was established.



ACF faces a key challenge related to this measure: the measure reflects the entire population and not just those served by TANF. The agency chose a national measure instead of a program-specific measure due to data constraints at the time the measure was added. It is possible that ACF will be able to influence this measure not only through the TANF program but also through the new Healthy Marriage and Responsible Fatherhood Initiatives, funded by the Deficit Reduction Act of 2005 (DRA). Although the Healthy Marriage and Responsible Fatherhood Initiatives have not established this measure as an indicator of their program success, ACF anticipates that these efforts may eventually help achieve the measure's FY 2009 target. Nevertheless, these efforts may not reach enough households to make a notable impact on the national marriage rate since grants are made to those with promising practices and not distributed uniformly across the country.

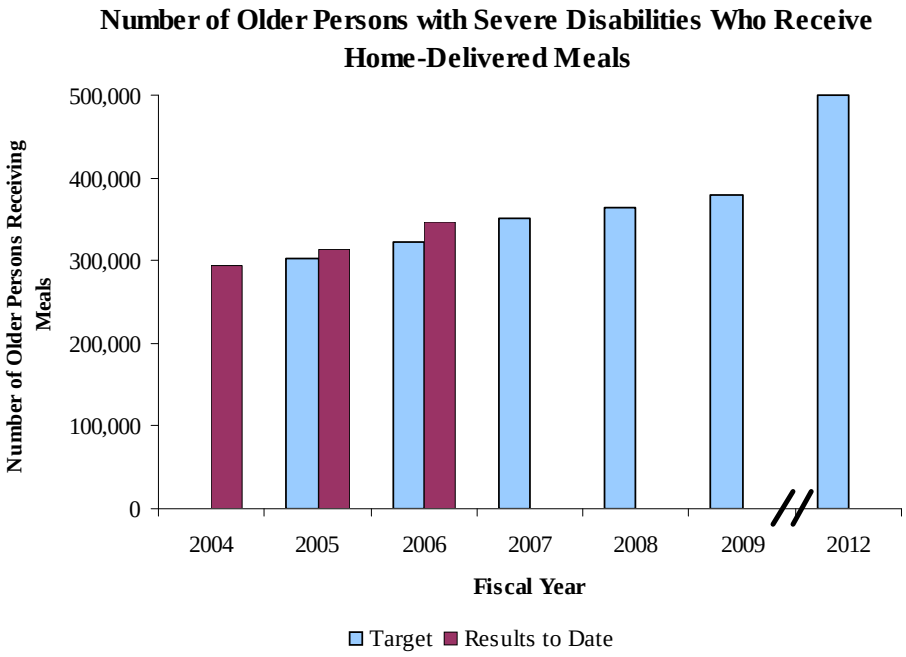
Considering all of these factors, ACF anticipates that 73 percent of children in all households will be living in married couple households in FY 2009, which would signal significant progress in the formation and maintenance of two-parent families. ACF is developing measures to capture other aspects of healthy marriage and responsible fatherhood in addition to the marital status of families in which children live, and these measures will be used by grantees. This will allow ACF to better target measures to those it serve as well as yield data directly relating to participants.

Data Source: The data for this measure, which has a one-year data lag, is obtained from Census Bureau surveys. Annual supplemental Census survey data provide reliable State and national estimates for this measure. Using expanded sampling by the Census Bureau, ACF can measure the extent to which children are living in married couple households.

<u>Performance Measure</u>: Increase the number of older persons with severe disabilities who receive home-delivered meals.

Description: This Administration on Aging (AoA) program provides home and community-based support to the elderly so that they may lead healthier and more independent lives. Services include meals, transportation, disease prevention classes, and caregiver support, which help elderly individuals remain in their homes and communities.

Performance: For this measure, which was established in 2005, an individual is considered severely disabled if they have three or more activities-of-daily-living (ADL) limitations, a level that is consistent with nursing home eligibility in most States. These limitations include activities related to personal care, such as bathing or showering, dressing, getting in or out of bed, using the toilet, and eating. In FY 2006, the most recent year for which data are available, the Aging Services Network provided home-delivered meals to 345,752 seniors with severe disabilities, a 17 percent increase over FY 2004. AoA exceeded its projected target of 322,522 by 7 percent, serving 23,230 more people with severe disabilities than projected for FY 2006. This better-than-expected performance can be attributed to the Aging Services Network's efforts to evaluate and demonstrate strategies to improve long-term care, efforts which target severely-disabled seniors. These included more States integrating Medicaid Waiver services with Aging Services Programs and demonstration projects to improve outreach.



The FY 2009 target is 378,613, an increase of 35 percent over the FY 2003 baseline. The program faces several challenges in meeting its goal to annually increase the number of severely-disabled clients who receive home-delivered meals, including the accelerating pace of food cost inflation and significant fuel cost increases which impact the cost of delivering meals to frail elderly clients. AoA is striving to address these challenges by working closely with States and the Aging Services Network to develop management efficiencies and local community support that will enhance service provision and continue targeting those most in need. Furthermore, AoA is continuing home and community-based long-term care demonstration efforts that target severely disabled seniors.

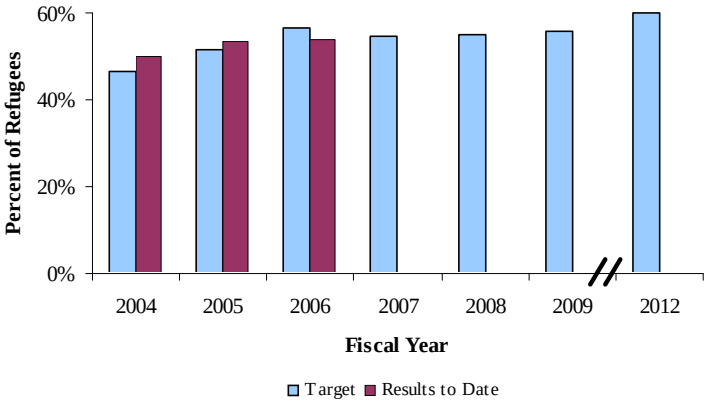
Data Source: The data for this measure, which has a one year data lag, is from AoA's National Aging Program Information System, State Program Reports, and National Surveys.

<u>Performance Measure</u>: Increase the percentage of refugees entering employment through refugee employment services funded by ACF.

Description: The Office of Refugee Resettlement (ORR) helps refugee and other eligible populations become employed and self-sufficient as quickly as possible. ORR funds State and non-profit organizations to provide services to refugee populations.

Performance: Targets for FY 2004 and FY 2005 were exceeded, and the percentage of refugees entering employment through ORR-funded services increased from 50 percent in FY 2004 to 53 percent in FY 2005, in part due to increased emphasis on employability services. State and non-profit's annual targets include a gain of three to five percent increase in the rate of refugees entering employment. ORR uses several strategies and incentives to challenge grantees to achieve their targets, including publishing outcomes in the Annual Report to Congress, presenting certificates of commendation to improved States at the annual National Consultation, and providing technical assistance and monitoring to grantees.

Percentage of Refugees Entering Employment Through Refugee Employment Services Funded by ACF



In FY 2006, 36,670 refugees (54 percent) were assisted with employment placements, narrowly missing the annual target of 56 percent. One of the key factors determining refugee employability is their English proficiency. Many of the activities funded by ORR focus on providing English Language Training in conjunction with specialized job training, on-the-job training, and short-term skills training targeted to local job markets. ORR-funded programs also provide supportive services such as transportation, interpretation, and child care services. These activities are designed to improve the program's performance by at least one percent over the previous year's result in FY 2009, and reach the long term goal of a 60 percent employment entry rate by FY 2012.

Due to the changing demographics of the refugee population, ORR faces continuing challenges in meeting employment targets. Recent arriving populations are ethnically diverse and in need of intensive services. For example, the U.S. State Department has indicated that Bhutanese, Burundian, and Burmese populations will be heavily represented among arrivals in FY 2008 and FY 2009. These groups face specific challenges to self-sufficiency. They have lived in refugee camps for extended periods of time and have mostly rural backgrounds and minimal work experience, as well as limited exposure to modern amenities and English language instruction. Many will be dealing with the effects of past trauma, including sexual and domestic violence, which impede employment success and self-sufficiency. Reports from the Burmese camps in Thailand indicate that significant numbers of women in the camp have been subjected to sexual and gender-based violence, resulting in additional trauma-related barriers to employment. Additionally, 12,000 Iraqi refugees are expected to be resettled in FY 2008, with larger numbers anticipated for FY 2009, and are likely to have suffered trauma due to persecution. These arrivals are expected to require intensive services to become self-sufficient.

Data Source: Data, which has a one-year lag, is obtained through ACF's Performance Reports (ORR-6), validated by periodic desk and on-site monitoring, in which refugee cases are randomly selected and reviewed. During on-site monitoring, reported outcomes are verified with both employers and refugees to ensure accuracy.

Strategic Goal 4: Scientific Research and Development

Advance scientific and biomedical research and development related to health and human services.

The four broad objectives under Scientific Research and Development are:

- Objective 4.1: Strengthen the pool of qualified health and behavioral science researchers;
- Objective 4.2: Increase basic scientific knowledge to improve human health and human development;
- Objective 4.3: Conduct and oversee applied research to improve health and well-being; and
- Objective 4.4: Communicate and transfer research results into clinical, public health, and human service practice.

People are living longer as a result of successes in preventing and treating acute and short-term conditions such as heart attacks, stroke, cancer, and many infectious diseases. An increasingly older population faces the new challenges of multiple chronic conditions that now consume 75 percent of health care expenditures. The Nation is in a continuous race against the health and economic consequences of disease and human suffering. Therefore, we must utilize research and development to its maximum capacity to transform health care, public health, and human service prevention efforts.

Basic science is the foundation for improved health and human services. Once a basic discovery is made, the findings must be applied and translated into practice for health and human service improvement to result. This continuum from basic to applied research to practice is a significant emphasis of HHS' scientific research and development enterprise.

Advances cannot be accomplished without qualified researchers working with, or for, HHS. The scientific labor market is highly competitive. HHS' National Institutes of Health (NIH) seeks to build and maintain a population of scientists that is well educated, highly trained, and dedicated to meeting the Nation's future health-related research needs primarily through its Extramural Research Training Program, and also through its Intramural Research efforts. NIH exceeded the training program's annual goals by initiating new research training and fellowship initiatives. In FY 2007, NIH post-doctoral scientists who had participated in the National Research Service Award Program had a 13 percent higher success rate for continuing participation in NIH-funded research within the following ten years as compared to their peers who did not participate in the program. This result exceeds the program goal of 12 percent. The Department will continue creating effective strategies to recruit and retain scientific experts to conduct and oversee research activities, and review applications for medical products.

The following pages discuss the performance indicators that support strategic goal 4 and highlight HHS' recent accomplishments and future targets. The table below shows HHS' progress in meeting targets for Strategic Plan measures for Strategic Goal 4 in this document.

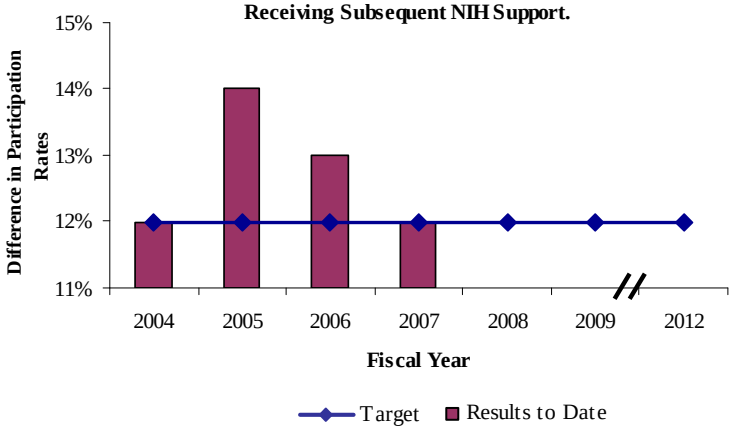
Fiscal Year	Total Targets	Targets with Results Reported			
		Number	%	Number	%
2004	5	5	100%	5	100%
2005	7	7	100%	7	100%
2006	7	7	100%	7	100%
2007	9	9	100%	9	100%

<u>Performance Measure</u>: Through the National Research Service Award Program, increase the probability that scientists continue participation in NIH-funded research within the following 10 years: a) Postdoctoral fellows; and b) Predoctoral trainees and fellows.

Description: The overall goal of the National Institute of Health (NIH) Extramural Research Training Program is to build and maintain a population of scientists that is well educated, highly trained, and dedicated to meeting the Nation's future health-related research needs. The extramural grant programs of NIH support a broad range of research education, training, and career development activities that utilize a variety of support mechanisms to meet NIH research training and career development goals.

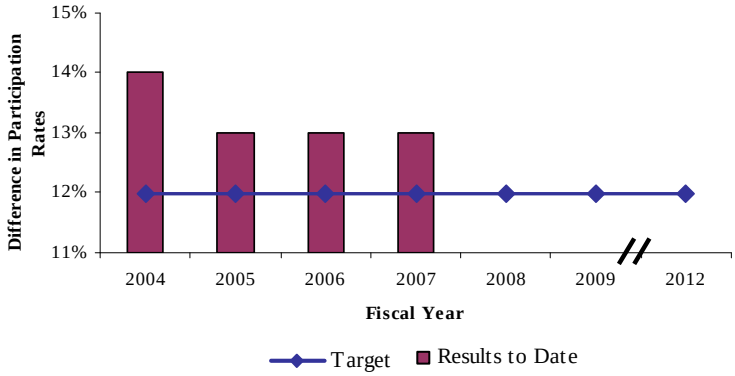
Performance: NIH routinely meets – or exceeds – this training program measure by adapting to the evolving needs of science, for example, by updating and developing new research training and fellowship initiatives. Through these and other efforts to manage the program, NIH ensures that its trainees and fellows are better prepared to initiate and maintain careers in biomedical research.

Difference in Percentage of NRSA *Pre-doctoral Trainees/Fellows* and Relevant Comparison Group Applying For and Receiving Subsequent NIH Support.



In FY 2007, NIH issued more than 40 new or updated education, research training, and career development funding opportunity announcements, including the announcement of the new, trans-NIH New Innovator Award. The New Innovator Award complements the K99/R00 Pathway to Independence Award, announced in 2006, and the existing K22 Career Transition Award offered by a number of NIH Institutes and Centers, all of which support promising new investigators. In FY 2007, NIH made more than 180 K99 awards and 40 K22 awards, as well as 29 New Innovator awards. These and other NIH career development awards provide indispensable opportunities for professional development after NRSA research training, foster the transition of newly-trained scientists into independent investigators, and play a key role in their retention in biomedical and behavioral research careers. As shown in the graphs, the National Research Service Award (NRSA) program prepares its participants to be more successful at obtaining these awards compared to their peers who do not participate in NRSA.

Difference in Percentage of NRSA *Post-doctoral Fellows* and Relevant Comparison Group Applying For and Receiving Subsequent NIH Support.



Data Source: The data for this measure is from the Outcome Evaluation of NIH National Research Service Award Postdoctoral Training Program.

<u>Performance Measure</u>: Develop and apply clinically one new imaging technique to enable tracking the mobility of stem cells within cardiovascular tissues.

Description: Scientists have begun testing cell-based treatments using stem and progenitor cells from a variety of tissues in humans, but imaging modalities are needed to track cells in intact animals and, ultimately, in humans. The ultimate goal of the research is to aid the development of cell-based therapies for cardiovascular disease. For example, several of the targets for the goal focus on cell-based therapy for peripheral arterial disease (PAD), a form of cardiovascular disease in which plaque builds up inside the walls of arteries that carry blood from the heart to the head, internal organs, and limbs. The plaque buildup causes the arteries to narrow or become blocked, which can reduce or prevent blood flow. PAD most commonly affects blood flow to the legs, and can cause pain, numbness, infection and, in severe cases, tissue death leading to amputation.

Performance: The initial pre-clinical targets for stem cell imaging for the goal have been completed successfully. Based on recent findings, researchers have realized the critical importance of control of stem cell differentiation to the success of stem cell-based therapy.

The FY 2007 target is not needed at this point since clinical studies would not be undertaken until further work could be done to improve understanding of the control of stem cell differentiation. NIH will continue to pursue this goal by supporting efforts to develop and enable tracking the mobility of stem cells in cardiovascular tissues, NIH-funded researchers will also focus on improving understanding of stem cell differentiation in order to develop methods to direct the differentiation or development of stem cells along specific cell lineages to yield replacement cells for clinical use. The planned FY 2008 target was achieved in FY 2007.

This is a high-risk, long term research goal. Stem cell research is still in its infancy and, as with all research, its outcomes may support proposed hypothesis or may lead to surprising new discoveries and findings that shift the research focus.

FY	Target	Actual
2005	Initiate stem cell labeling strategy.	(MET) NIH-researchers successfully developed an optical microscope system to monitor single cells in intact animals.
2006	Complete optical imaging probe development.	(MET) Researchers in the NIH intramural program have developed probes that are compatible with optical microscopy techniques developed by intramural scientists.
2007	Initiate validation and toxicity studies.	(NOT MET) Due to changes in the scientific field and a new direction for this goal, this step to initiate and validate toxicology studies was not needed at this time. (MET in 2007) NIH scientists have undertaken studies of the nature of stem cell migration in adult tissues including a preclinical study in a rat model.
	(FY08) Initiate preclinical studies on the nature of stem cell migration in adult tissue.	
2008	Formulate a biocompatible cell encapsulation agent designed to protect and track mesenchymal stem cells for administration to patients to promote cell survival and engraftment.	Available February 2009
2009	Demonstrate that encapsulated cells can be tracked non-invasively by X-ray computed tomography.	Available February 2010
2012	Develop one new imaging technique that is able to be clinically applied.	Available February 2013

Data Source: The data for this measure is from NIH study data.

<u>Performance Measure</u>: Identify at least one clinical intervention that will delay the progression or the onset of Alzheimer's disease (AD) or prevent it.

Description: Given the aging population, Alzheimer's disease (AD) is a steadily increasing national health problem. Interventions that could delay or prevent the onset of AD would have an enormous positive public health impact because they would greatly reduce the number of people with the disease.

Performance: NIH has made progress in a number of areas and is continuing to facilitate discovery in each of these areas: neuroimaging and other biological markers, genetics, basic research, pre-clinical and translational research, and clinical trials.

NIH has released two currently active research solicitations to facilitate the discovery, development, and preclinical testing of novel compounds for the prevention and treatment of the cognitive and behavioral symptoms associated with AD. Twenty-four projects are currently funded through these solicitations. These projects are exploring a wide array of approaches, including agents that inhibit the development of AD's characteristic amyloid plaques and neurofibrillary tangles, immunotherapies, antioxidant drugs, and neuroprotective agents.

FY	Target	Actual
2004	Identify and implement effective strategies to facilitate drug discovery and development for AD treatment and prevention in collaboration with relevant organizations, as well as through stimulation of relevant research through Program Announcements and/or other mechanisms.	(MET) NIH continued a preclinical toxicology program and expanded a program for pre-clinical drug discovery and development.
2005	Launch the Alzheimer's Disease Neuroimaging Initiative to evaluate neuroimaging modalities and techniques and other biomarkers to be used in early diagnosis, follow the progression of mild cognitive impairment (MCI) and AD, and use as potential surrogate markers for drug development and clinical trials.	(MET) The NIH launched the Alzheimer's Disease Neuroimaging Initiative in late 2004.
2006	Identify around 1,000 new late onset AD families to allow geneticists to locate additional late onset risk factor genes for AD that may lead to new targets for drug treatment, and provide a well-characterized population for more efficient clinical trials.	(MET) Nearly 1,000 new late-onset AD families have been identified and recruited to the AD Genetics Initiative.
2007	Identify and characterize molecular events that may prove to be targets for treating or preventing Alzheimer's disease through initiatives and projects focused on mechanistic and basic studies.	(MET) NIH-supported research has helped to identify and characterize two particularly promising target molecules for AD treatment and development: beta-amyloid production and p38 alpha MAPK.
2008	For at least one promising drug candidate for the treatment of AD, complete at least one of the four preclinical steps necessary for regulatory approval: chemical optimization; proof of efficacy in an animal model relevant to the disease; pharmacokinetic profiling; and/or early toxicology screening.	Available February 2009
2009	Start at least one pilot clinical trial on promising interventions based on results of previous trials and new leads for drug discovery.	Available February 2010
2012	Identify next generation of compounds for testing in pilot clinical trials.	Available February 2013

This is a high risk, long term research outcome that is challenging to predict with a high degree of accuracy. The outcomes may encompass the proposed hypothesis, but unplanned results such as serendipitous discoveries and findings that narrow the avenue of the research focus (elimination discoveries) can be just as significant.

Data Source: The data for this measure is from NIH study data.

<u>Performance Measure</u>: Develop a novel advanced pattern recognition algorithm to analyze data obtained from imaging technologies to aid clinicians in diagnosing the earliest stage of disease, e.g., brain cancer.

Description: The National Center for Toxicological Research (NCTR) supports efforts to enhance product safety by creating new and sophisticated analytical models that will assist the Food and Drug Administration (FDA) in continuing assessments of regulated products. The efforts are directed towards the creation of a more quantitative risk-based approach that will support the design of products that prevent, diagnose and treat disease.

Performance: NCTR scientists in the Division of Systems Toxicology designed and trained a prototype pattern recognition algorithm to detect normal and anomalous tissue using non-invasive magnetic resonance spectroscopy (MRS) brain scans. The advanced pattern recognition algorithm was developed to increase the ease and accuracy of interpreting complex MRS scans that are expected to detect early-stage cancers. The project was initiated in 2006 to test the hypothesis that the NCTR developed pattern recognition algorithms developed for food safety applications may be used to enhance the interpretation of imaging data.

In FY 2007, the pilot experiment indicates that the algorithm developed from 30 MRS brain scans can distinguish normal from abnormal tissue. In FY 2008, the experiment will be expanded to include more than 100 brain scans which should be a large enough number to confirm the pilot discovery and to determine whether the approach also can provide enough information to classify and grade tumors. The ultimate goal of this project is to work with private sector partners to develop and apply pattern recognition algorithms to identify early biomarkers of brain disease and other clinical applications such as detection of breast and prostate cancer markers. This project may lead to improved tumor diagnostic techniques and provide more affordable noninvasive tissue screening for disease.

The challenge for clinicians to utilize emerging and typically high-dollar medical technologies for the detection and staging of disease in routine health care is to have equally powerful and automated interpretive aids. FDA is evaluating whether a variation of its experimental pattern recognition technology can be successfully applied as an interpretation aid for MRS scans. New technologies often generate enormous and complex data outputs that can defy visual interpretation. Computerized pattern evaluations must avoid false negative and minimize false positive interpretation. Overcoming these challenges is an important step to improve the affordability and effectiveness of consumer health.

FY	Target	Actual
2007	Proof of principle that pattern recognition can supplement MRS brain scan interpretation.	(Met) The prototype algorithm was successfully developed from 30 MRS brain scans.
2008	Determine extent of algorithm limitations (e.g. staging disease) using increased number of test brain scans.	Available October 2008
2009	Develop CRADA partnership to explore application of pattern recognition to other tissues and diseases (e.g prostate disease).	Available September 2009
2010	Continue collaboration with CRADA partner in the application of the pattern recognition algorithm.	Available November 2010
2011	Apply a pattern recognition algorithm to identify early biomarkers of brain disease to other disease endpoints in clinical applications such as those used to identify early Parkinson's disease markers.	Available June 2011
2012	Expand the pattern recognition algorithm to enable noninvasive tissue screening for disease.	Available September 2013

Data Source: The data for this measure is from Annual NCTR Research Accomplishments and Plans document located at: http://www.fda.gov/nctr/science/research_index.htm.

<u>Performance Measure</u>: Conduct clinical trials to assess the efficacy of at least three new treatment strategies to reduce cardiovascular morbidity / mortality in patients with type 2 diabetes and / or chronic kidney disease.

Description: NIH is addressing a significant public health problem by seeking to evaluate approaches for reducing cardiovascular disease (CVD) outcomes, such as heart attacks and strokes, in patients with type 2 diabetes and/or chronic kidney disease for whom premature CVD is the major cause of death. Application of the results of the trials, if favorable, would extend the lifespan and improve the quality of life for persons with type 2 diabetes or kidney disease.

Performance: NIH has been successful in achieving the annual targets for this goal, which are derived from a set of major, multicenter, randomized clinical trials. The set of trials is unparalleled in scope and research intensity and, collectively, could not be replicated by other organizations.

The Look AHEAD one-year outcome data paper was published in *Diabetes Care* in 2007[1]. Two papers describing the baseline characteristics of participants in the Bypass Angioplasty Revascularization Investigation in Type 2 Diabetes (BARI 2D) trial have been completed, but are not yet published.

Research outcomes are challenging to predict with a high degree of accuracy, but can be captured in many cases with milestones of progress toward the goal. Although outcomes may encompass the proposed hypothesis, unplanned results such as serendipitous discoveries and findings that narrow the research focus (elimination discoveries) can be just as significant.

FY	Target	Actual
2004	Complete recruitment for the Action for Health in Diabetes (Look AHEAD) study (5,000 patients), in order to compare the effects on cardiovascular events of an intensive lifestyle intervention designed to achieve and sustain weight loss versus support and education in obese individuals with type 2 diabetes.	(MET) Look AHEAD exceeded its target goal of 5000 obese patients who have type 2 diabetes, and enrolled 5,145 participants by May 2004.
2005	Complete recruitment for the Action to Control Cardiovascular Risk in Diabetes (ACCORD) study (10,000 patients), which is comparing effects on CVD of intensive versus conventional interventions of lowering blood glucose, blood pressure; and treating blood lipids in diabetic patients at high risk for CVD.	(MET) The NIH enrolled 10,000 patients in the Action to Control Cardiovascular Risk in Diabetes (ACCORD) trial by September 30, 2005.
2006	Look AHEAD aims to report outcome data on the success of the one-year intensive weight loss intervention and its impact on CVD risk factors such as diabetes control, lipids, blood pressure, and fitness.	(MET) Initial findings were made public at the annual American Diabetes Association in June 2006.
2007	Complete at least 90% of the total enrollment for the Folic Acid for Vascular Outcome Reduction in Transplantation (FAVORIT) trial which aims to determine whether reduction of total homocysteine by means of a multivitamin in clinically stable kidney transplant recipients results in significant reduction in atherosclerotic CVD.	(MET) FAVORIT enrolled and randomized the total trial population (4,000 patients) from sites located in the United States, Canada, and Brazil, by January 2007.
2008	Review and evaluate collectively, indicators of Look AHEAD's progress to date (measures such as safety-monitoring analyses, data quality, participant retention, and emerging positive or negative outcome trends) in order to determine whether the science is progressing appropriately--in accord with the clinical trial's protocol--and whether the trial will be continued.	Available February 2009
2009	Complete treatment and follow-up of participants in the ACCORD trial to determine effects of glycemia, blood pressure, and blood lipid treatment approaches to prevent CVD in diabetes.	Available February 2010
2012	Complete clinical trials and make results available.	Available February 2013

Data Source: The data for this measure is from NIH study data.

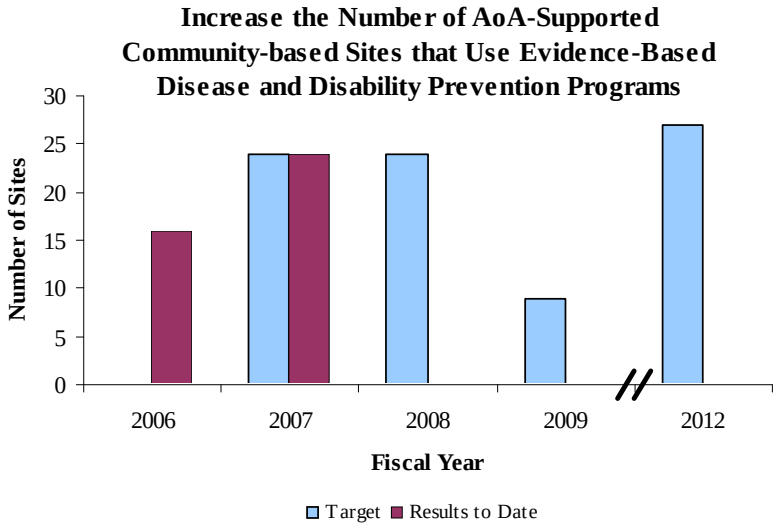
[1]The Look AHEAD Research Group. **Reduction in Weight and Cardiovascular Disease Risk Factors in Individuals With Type 2 Diabetes: One-year results of the Look AHEAD trial.** *Diabetes Care* 30:1374-1383, 2007.

<u>Performance Measure</u>: Increase the number of AoA-supported community-based sites that use evidence-based disease and disability prevention programs.

Description: The Evidence-Based Disease and Disability Prevention (EBDP) Program, through the Administration on Aging (AoA), empowers older people to take control over their own health through lifestyle changes that have proven effective in reducing the risk of disease and disability among the elderly and enabling those with chronic conditions to better manage their own care. Currently, the primary program components are: Chronic Disease Self-Care; Physical Activity; Falls Prevention; Nutrition and Diet; and Depression.

***Performance*:** Between FY 2003 and FY 2006, AoA funded 12 community-level sites to demonstrate and evaluate the capacity of the Aging Services Network to successfully implement EBDP programs validated by HHS-sponsored research. The evaluation results of the EBDP program confirmed the capability of the Aging Services Network to effectively deliver EBDP community programs to diverse elderly populations.

In FY 2006, AoA provided funds to 16 states to build capacity to replicate, manage, and provide program operating funds for the EDBP program through the Aging Services Network. In FY 2007, an additional eight States were awarded grants to implement similar programs. Presently, 27 AoA-supported community-based sites are using EBDP programs. This exceeds the FY 2008 target of three sites in each of eight States. In FY 2009, AoA will target specific funds for 9 sites in up to five States as part of the Choices for Independence demonstration. Choices for Independence will evaluate whether savings in Medicaid and Medicare can be achieved through the use of low-cost home and community-based alternatives, including evidence-based prevention activities. Because these efforts will be targeted at three to five demonstration States, fewer sites will be funded in FY 2009.



AoA faces several challenges in meeting the long-term target of 27 sites by FY 2012. For example, expanding these programs to additional sites requires substantial training and program development to establish and maintain fidelity to the original program design and to assure health benefits for older adult clients. AoA has helped the current sites overcome these challenges by requiring the programs to partner with State and local health agencies and other organizations. States, public and private agencies, and foundations at every level have been receptive to EBDP programs. Because many older adults are receptive to an opportunity to learn and make behavioral changes that will help them manage their chronic diseases, the programs are gaining momentum.

Data Source: The data for this measure is from AoA's Evidence-Based Disease Prevention discretionary grant semiannual reports.

<u>Performance Measure</u>: Reduce the disparity between African American and White infants in back sleeping by 50% to reduce the risk of Sudden Infant Death Syndrome (SIDS).

Description: The NIH, in collaboration with campaign sponsors, is leading the national Back to Sleep public health education campaign, which promotes placing babies on their backs to sleep to reduce the risk of SIDS.

Performance: The NIH has successfully implemented comprehensive strategies to promote safe sleeping practices in African American communities. First, the NIH launched a multi-year project to disseminate the American Academy of Pediatrics safe sleep guidelines in Mississippi. Second, a continuing education curriculum was developed for nurses on the safe sleep guidelines and effective ways to convey the risk reduction message. This curriculum is being implemented at regional and national conferences.

The NIH continues to promote and disseminate the nurses' continuing education (CE) module, Continuing Education Program on SIDS Risk Reduction, which was created in collaboration with national nursing and health organizations across the country. In 2007, CE courses were conducted at four national and six regional nursing conferences. There were 413 nurses who completed the nursing modules and received CE credit. The trainings at national and regional nurse organizations, as well as hospital-based trainings will provide an opportunity for nurses to come into contact with the curriculum on several levels, which can then lead to sustainability through institutionalization of the recommendations.

A challenge to this goal is the lack of a quality national data source to measure the impact of the SIDS outreach campaign. The national data source uses convenience sampling, which is not representative of the population as a whole and may not reflect the full achievements of the program. To address this challenge, the NIH recently announced a Request for Applications (RFA) to examine trends in infant care practices, and environmental and cultural influences on the diffusion of the public health recommendations in a nationally representative sample of minority and non-minority mothers.

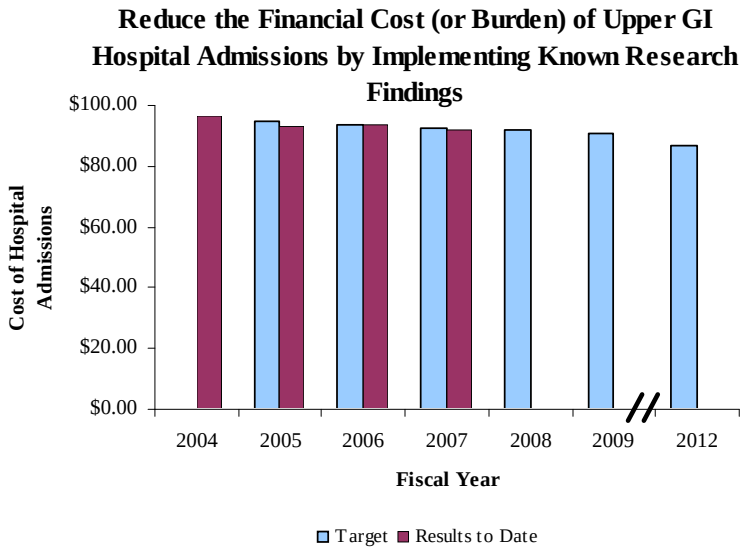
FY	Target	Actual
2004	Conduct 250 interviews among the approximately 1,500 participants who attended the three summit meetings held in FY 2003 to determine that each summit resulted in a minimum of 50 outreach activities.	(MET) Interviews were held with participants from each summit and 150 outreach activities resulted from each of the summits.
2005	Continue to extend 'Back to Sleep' campaign messages to African American populations through community-based collaborations/partnerships by involving a minimum of six national organizations in SIDS training and educational activities.	(MET) NIH extended the 'Back to Sleep' campaign messages to African American populations through community-based collaborations with eight national organizations in SIDS training and educational activities.
2006	Promote a continuing education module with at least six national nursing organizations serving African American communities to extend the Back to Sleep campaign messages.	(MET) The Nurses Continuing Education Program was presented at eight national and four regional nurses conferences. Approximately 5,250 nurses participated in the training.
2007	Extend the continuing education module for nurses in appropriate community-based clinical settings in African American communities in the Mississippi Delta region.	(MET) NIH extended the continuing education module to approximately 50 nurses in the Mississippi Delta Region.
2008	Distribute approximately 43,000 special "Back to Sleep" campaign materials targeting African American communities in collaboration with the Arkansas Department of Health.	Available February 2009
2009	Conduct a continuing education program for approximately 500 pharmacists in the DC metro area.	Available February 2010
2012	Reduce disparity by 50%.	Available February 2013

Data Source: The data for this measure is from NIH study data.

<u>Performance Measure</u>: Reduce the financial cost (or burden) of upper gastrointestinal (GI) hospital admissions by implementing known research findings.

Description: The Agency for Healthcare Research and Quality (AHRQ) manages the Effective Health Care Program, which supports the development of new scientific information through research on the outcomes of health care services and therapies by comparing different therapies for the same condition. This program helps policymakers, clinicians, and patients determine which drugs and other medical treatments work best for certain health conditions. The Effective Health Care Program includes the Centers for Education & Research on Therapeutics (CERTs), Developing Evidence to Inform Decisions about Effectiveness (DEcIDE) Research Network, Evidence-based Practice Centers (EPC) Program, and The John M Eisenberg Clinical Decisions and Communications Science Center.

Performance: Results show that from FY 2004 through FY 2006, the number of hospital admissions for GI bleeding due to adverse events of medication or inappropriate treatment of peptic ulcer disease in those between 65 and 85 years of age have generated a decrease each year in per capita charges for GI bleeding. The per capita charges for GI admissions have consistently been reduced beyond the targeted performance. This performance may be related to research findings that AHRQ has disseminated to health care providers for doctors to use. However, external factors could have affected this performance trend. Increased monitoring of pharmaceuticals that commonly cause the side effect of GI bleeding could have affected the number of hospitalizations.



In FY 2007, AHRQ met its target to decrease per capita charges for upper GI admissions to $92.68 by reducing per capita charges to $91.81. Given the past trend, AHRQ expects that hospitalization for upper GI bleeding will decrease, and consequently, the per capita charges will continue to decrease. In FY 2008, AHRQ aims to reduce per capita charges for upper GI admissions to $91.71 and in FY 2009 to $90.75.

AHRQ faces many challenges in meeting its performance for this measure because external factors may prevent health care professionals from implementing findings from AHRQ funded-research. For instance, the CERTs program recently completed a study showing that co-prescribing proton-pump inhibitor medications with drugs used to treat arthritis can reduce GI bleeding. Despite this study, this method to reduce GI bleeding is not used for many patients. Preliminary investigations in one State Medicaid agency suggest that infrequent use of this method may be due to formulary policies. As a result, AHRQ is working to disseminate the findings of the proton-pump inhibitor medications study to health care policy decision makers and is pursuing additional research and policy studies on the issue.

Data Source: The data for this measure is from AHRQ's Healthcare Cost and Utilization Project.

Analysis of Financial Statements and Stewardship Information Section

Analysis of Financial Statements: For the ninth consecutive year, The Department of Health and Human Services (HHS) received an unqualified or "clean" audit opinion on its financial statements. The financial statements were prepared in accordance with Federal accounting standards and audited by the independent accounting firm of PricewaterhouseCoopers, LLP, under the direction of HHS' Inspector General. Preparation and audit of these statements are required by the Chief Financial Officers Act of 1990 and are part of the Department's efforts for continuous improvement of financial management. The production of accurate and reliable financial information is necessary for sound decision-making, assessing performance, and allocating resources. The Department's audited financial statements and notes are presented in Section II of the *Agency Financial Report (AFR)*, which can be accessed at www.hhs.gov/afr/financial/index.html. A summary of that report is below.

Financial Condition – What is Our Financial Picture? The following charts summarize trend information concerning components of our financial condition - assets, liabilities, net position, and net cost of operations. The consolidated Balance Sheet presents a picture of our financial condition as of September 30, 2007, as compared to FY 2006, and displays assets, liabilities and net position. Another component of our financial picture is our consolidated Statement of Net Cost. Each of these components is discussed below.

FINANCIAL CONDITION *(Dollars in Billions)*	FY 2003 Restated	FY 2004	FY 2005	FY 2006	FY 2007	Increase (Decrease)	% Change
Total Assets	**$389.3**	**$403.8**	**$428.5**	**$513.9**	**$503.8**	**$(10.1)**	**(2.0%)**
Fund Balance with Treasury	86.3	97.7	99.6	159.9	114.8	(45.1)	(28.2%)
Investments, Net	282.4	287.9	300.7	342.0	365.9	23.9	7.0%
Other Assets	20.6	18.2	28.2	12.0	23.1	11.1	92.5%
Total Liabilities	**$63.2**	**$66.8**	**$71.0**	**$78.4**	**$81.9**	**$3.5**	**4.5%**
Accounts Payable	1.2	1.4	1.1	1.2	1.0	(0.2)	(16.7 %)
Entitlement Benefits Due and Payable	48.1	49.2	53.8	61.2	61.5	0.3	0.5%
Accrued Grant Liabilities	3.8	3.8	3.8	3.8	3.9	0.1	2.6%
Federal Employee & Veterans Benefits	6.9	7.2	7.2	7.5	8.4	0.9	12.0%
Other Liabilities	3.2	5.2	5.1	4.7	7.1	2.4	51.1%
Net Position	**$326.1**	**$337.0**	**$357.5**	**$435.5**	**$421.9**	**$(13.6)**	**(3.1%)**
Total Liabilities and Net Position	**$389.3**	**$403.8**	**$428.5**	**$513.9**	**$503.8**	**$(10.1)**	**(2.0%)**

Assets represent the amounts that we own or manage. Our assets were $503.8 billion at the end of FY 2007. This represents a decrease of $10.1 billion (-2.0 percent) below the prior year's assets. This decrease is largely attributable to the net effect of a decrease of $45.1 billion in Fund Balance with Treasury and an increase of $23.9 billion in Net Investments.

Our liabilities at the end of FY 2007, or amounts that we owe as a result of past transactions or events, were $81.9 billion. This represents an increase of $3.5 billion, or 4.5 percent above the prior year's liabilities. The majority of the increase is from an increase in Other Liabilities ($2.4 billion) and Federal Employee & Veterans Benefits ($0.9 billion). Entitlement benefits due and payable to the public from the Medicare and Medicaid insurance programs represent more than 75 percent of the liabilities.

Our net position represents the difference between assets and liabilities. Changes to our net position are impacted by changes that occur within cumulative results of operations and unexpended appropriations. At the end of FY 2007, HHS' Net Position shown on the Consolidated Balance Sheet and the Consolidated Statement of Changes in Net Position was $421.9 billion, a decrease of $13.6 billion (3.1 percent) from the previous year. This was due to the net effect of an increase of $29.2 billion in cumulative results of operations and a decrease of $42.8 billion in unexpended appropriations.

Our net cost of operations represents the difference between the costs incurred by our program less receipts. We receive the majority of funding through Congressional appropriations and reimbursement

for the provision of goods or services to other Federal agencies. HHS net cost of operations during FY 2007, depicted below, totalled $664.6 billion. This represents an increase of $40.7 billion, or 6.5 percent more than FY 2006 costs of $623.9 billion. The Medicare program accounted for the majority of the increase for FY 2007.

NET COST OF OPERATIONS *(Dollars in Billions)*	2007	2006
Responsibility Segments		
Centers for Medicare & Medicaid Services (CMS) Gross Cost	$ 612.4	$ 574.2
CMS Exchange Revenue	(50.3)	(49.8)
CMS Net Cost of Operations	$ 562.1	$ 524.4
Other Segments:		
Administration for Children & Families (ACF)	$ 47.3	$ 47.1
Administration on Aging (AoA)	1.4	1.4
Agency for Healthcare Research & Quality (AHRQ)	.1	0.0
Centers for Disease Control & Prevention (CDC)	8.1	6.6
Food & Drug Administration (FDA)	1.9	1.9
Health Resources & Services Administration (HRSA)	6.9	6.2
Indian Health Service (IHS)	4.3	4.1
National Institutes of Health (NIH)	28.5	28.1
Office of the Secretary (OS)	2.2	2.6
Program Support Center (PSC)	1.4	.9
Substance Abuse & Mental Health Services Administration (SAMHSA)	3.3	3.3
Other Segments Gross Cost of Operations	$ 105.4	$ 102.2
Exchange Revenue	(2.9)	(2.7)
Other Segments Net Cost of Operations	$ 102.5	$ 99.5
Net Cost of Operations	**$ 664.6**	**$ 623.9**

Summary of Financial Statement Audit: The charts below present the results of our FY 2007 independent audit, conducted by Price Waterhouse Coopers, LLP. Further information concerning the Department's top management challenges and actions to resolve Office of the Inspector General (OIG) audit findings can be found in Section III of the *AFR* available at www.hhs.gov/afr/information/index.html. To ensure good stewardship of taxpayer resources, the Department is committed to efforts to make improvements related to these challenges.

Audit Opinion	Unqualified				
Restatement	No				
Material Weaknesses	**Beginning Balance[1]**	**New**	**Resolved[2]**	**Consolidated[3]**	**Ending Balance[4]**
Financial Management Systems & Reporting	X				X
Budgetary Accounting		X			X
Financial Management Information Systems	X				X
Medicare Claims Processing		X			X
Total Material Weaknesses	2	2	0	0	4

[1] The beginning balance shall agree with the ending balance of material weaknesses from the prior year.

[2] The total number of material weaknesses that have dropped below the level of materiality in the current year.

[3] The combining of two or more findings

[4] The agency's year-end balance.

Appendix Section

Appendix 1: HHS Agencies by Strategic Goal

To reach its goals, the Department of Health and Human Services (HHS) places the utmost importance on fostering a culture of leadership and accountability through responsible stewardship and effective management. The chart below shows HHS' components, their missions, and the Department-wide strategic goal(s) to which they are major contributors.

HHS Agencies by Strategic Goal

HHS Agency	Agency Mission	Goal 1: Health Care	Goal 2: Public Health	Goal 3: Human Services	Goal 4: Scientific Research & Development
Administration for Children and Families	*To promote the economic and social well-being of families, children, individuals, and communities.*			X	
Agency for Healthcare Research and Quantity	*To improve the quality, safety, efficiency, and effectiveness of health care for all Americans.*	X	X		X
Administration on Aging	*To promote the dignity and independence of older people, and to help society prepare for an aging population.*			X	
Agency for Toxic Substances and Disease Registry	*To serve the public by using the best science, taking responsive public health actions, and providing trusted health information to prevent harmful exposures and diseases related to toxic substances.*	X	X		X
Center for Disease Control and Prevention	*To promote health and quality of life by preventing and controlling disease, injury, and disability.*	X	X		X
Centers for Medicare & Medicaid Services	*To ensure effective, up-to-date health care coverage and to promote quality care for beneficiaries.*	X	X		
Food and Drug Administration	*To rigorously assure the safety, efficacy, and security of human and veterinary drugs, biological products, and medical devices, and assure the safety and security of the Nation's food supply, cosmetics, and products that emit radiation.*	X	X		
Health Resources and Services Administration	*To provide the national leadership, program resources, and services needed to improve access to culturally competent, quality health care.*	X	X		
Indian Health Service	*To raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level.*	X	X		X
National Institutes of Health	*To employ science in pursuit of fundamental knowledge about the nature and behavior of living systems and the application of that knowledge to extend healthy life and reduce the burdens of illness and disability.*	X	X	X	X
Substance Abuse and Mental Health Services Administration	*To build resilience and facilitate recovery for people with or at risk for substance abuse and mental illness.*	X	X	X	

Appendix 2: HHS Budget by Strategic Goal

This table displays funding by HHS Strategic Goal. It is the full cost estimate for HHS' activities in each area. The size, complexity and interdependence of HHS agencies' activities currently preclude the distribution of cost at the performance measure level.

	Dollars in Millions		
	FY2007	**FY2008**	**FY2009**
Strategic Goal 1: Health Care - Improve the safety, quality, affordability and accessibility of health care, including behavioral health care and long-term care.			
1.1 Broaden health insurance and long-term care coverage.	$644,034	$670,567	$715,619
1.2 Increase health care service availability and accessibility.	17,274	17,174	17,427
1.3 Improve health care quality, safety and cost/value.	1,870	2,006	2,040
1.4 Recruit, develop, and retain a competent health care workforce.	945	966	426
TOTAL	**$664,124**	**$690,714**	**$735,513**
Strategic Goal 2: Public Health Promotion and Protection, Disease Prevention, and Emergency - Preparedness - Prevent and control disease, injury, illness and disability across the lifespan, and protect the public from infections, occupational, environmental and terrorist threats.			
2.1 Prevent the spread of infectious diseases.	$5,078	$5,236	$5,374
2.2 Protect the public against injuries and environmental threats.	999	1,096	1,057
2.3 Promote and encourage preventive health care, including mental health, lifelong healthy behaviors and recovery.	2,307	2,229	2,147
2.4: Prepare for and respond to natural and man-made disasters.	2,165	2,083	2,239
TOTAL	**$10,550**	**$10,643**	**$10,817**
Strategic Goal 3: Human Services - Promote the economic and social well-being of individuals, families and communities.			
3.1: Promote the economic independence and social well-being of individuals and families across the lifespan.	$29,891	$29,924	$28,914
3.2: Protect the safety and foster the well-being of children and youth.	15,369	15,366	15,559
3.3: Encourage the development of strong, healthy and supportive communities.	2,444	2,461	1,285
3.4: Address the needs, strengths and abilities of vulnerable populations.	1,278	1,361	1,334
TOTAL	**$48,982**	**$49,112**	**$47,092**
Strategic Goal 4: Scientific Research and Development - Advance scientific and biomedical research and development related to health and human services.			
4.1: Strengthen the pool of qualified health and behavioral science researchers.	$1,505	$1,538	$1,503
4.2: Increase basic scientific knowledge to improve human health and human development.	15,814	16,004	15,942
4.3: Conduct and oversee applied research to improve health and well-being.	12,756	12,905	12,769
4.4: Communicate and transfer research results into clinical, public health and human service practice.	273	314	439
TOTAL	**$30,349**	**$30,761**	**$30,652**

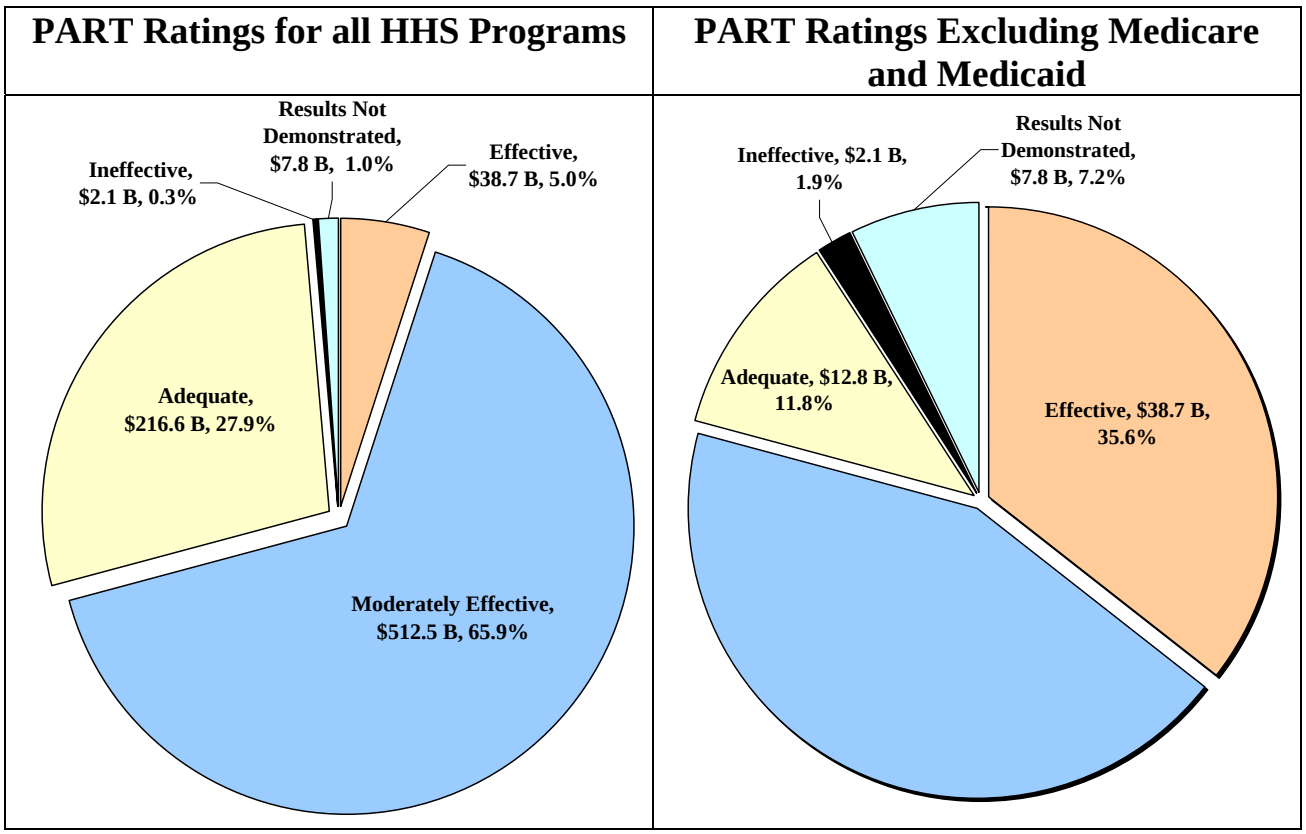
Appendix 3: Program Assessment Rating Tool (PART)

The Nation expects the projects and activities it funds to achieve results. A key gauge of Federal program effectiveness is the Program Assessment Rating Tool (PART), introduced in 2002. Its overall purpose is to assess program performance and results. The PART contains four sections: program purpose and design, strategic planning, program management, and program results. Programs receive ratings of Effective, Moderately Effective, Adequate, Ineffective, and Results Not Demonstrated (RND).

HHS uses PART results to inform management and budget decisions throughout the year to improve program performance and efficiency. PART results are included each year in the Department's summer budget development process. Additionally, HHS ensures that programs use the PART to improve program performance, especially programs that received an RND rating.

Since 2002, all significant HHS programs, and 99 percent of HHS' budget, have been assessed through the PART process. Overall, programs representing nearly 97 percent of HHS' budget were rated Adequate or better. Most important, HHS also greatly reduced the number of programs for which results cannot be demonstrated – in other words, programs which lack adequate measures that would indicate whether or not they are effective. The two charts below show HHS' PART Ratings, with and without the Department's two largest programs. For more detailed information on PART results for HHS programs, please see www.Expectmore.gov.

HHS PART Ratings (by Dollar)*



*Values based on FY 2008 enacted funding levels

HHS PARTed Programs (Dollars in Millions)

	PART Cycle	Narrative Rating	FY 2008 Enacted
Food and Drug Administration:			
Overall	CY 2003	Moderately Effective	$2,292
Health Resources and Services Administration:			
Health Professions	CY 2002	Ineffective	318
Maternal and Child Health Block Grant	CY 2002	Moderately Effective	666
National Health Service Corps	CY 2002	Moderately Effective	123
Nursing Education Loan Repayment and Scholarship	CY 2002	Adequate	31
Children's Hospital Graduate Medical Education Program	CY 2003	Adequate	302
Rural Health Activities	CY 2003	Adequate	167
Emergency Medical Services for Children	CY 2004	RND	19
National Bone Marrow Donor Registry	CY 2004	Moderately Effective	24
Organ Transplantation	CY 2004	Adequate	23
Poison Control Centers	CY 2004	Adequate	27
Traumatic Brain Injury	CY 2004	RND	9
Family Planning (managed by OPHS)	CY 2005	Moderately Effective	300
Health Care Facilities Construction	CY 2005	RND	304
Healthy Community Access Program	CY 2005	Ineffective	0
State Planning Grant Program - Uninsured	CY 2005	Ineffective	0
Trauma/Emergency Medical Services	CY 2005	Adequate	0
Universal Newborn Hearing Screening	CY 2005	Moderately Effective	12
Black Lung Clinics	CY 2006	Ineffective	6
Free Clinics Medical Malpractice Coverage	CY 2006	Adequate	0
Hansen's Disease Services Program	CY 2006	Moderately Effective	18
Healthy Start	CY 2006	Moderately Effective	100
National Practitioner/Health Integrity Data Banks	CY 2006	Moderately Effective	22
Radiation Exposure Screening and Education Program	CY 2006	Ineffective	2
Telehealth	CY 2006	Moderately Effective	7
Health Centers	CY 2007	Effective	2,022
Ryan White	CY 2007	Effective	2,142
Indian Health Service:			
Federally Administered Activities	CY 2002	Moderately Effective	2,105
Resource and Patient Management System	CY 2003	Effective	69
Urban Health	CY 2003	Adequate	35
Health Facilities Construction	CY 2004	Effective	37
Tribally Operated Health Programs	CY 2005	Adequate	1,804
Sanitation Facilities Construction	CY 2007	Moderately Effective	94
Centers for Disease Control and Prevention:			
317 Immunization Program	CY 2002	Adequate	527
State/Local Public Preparedness	CY 2003	RND	746
Buildings and Facilities	CY 2004	Adequate	55
Infectious Diseases	CY 2004	Adequate	218
Occupational Safety and Health	CY 2004	Adequate	287
Environmental Health	CY 2005	Adequate	154
Global Immunizations	CY 2005	Effective	140
Health Statistics	CY 2005	Moderately Effective	114
Strategic National Stockpile	CY 2005	Moderately Effective	552
Birth Defects and Developmental Disabilities	CY 2006	Moderately Effective	127

HHS PARTed Programs (Dollars in Millions)

	PART Cycle	Narrative Rating	FY 2008 Enacted
Chronic Disease Prevention	CY 2006	Moderately Effective	$834
Injury Prevention and Control	CY 2006	Moderately Effective	135
Terrorism: Intramural Activities	CY 2006	RND	121
Terrorism: Biosurveillance	CY 2006	RND	53
Agency for Toxic Substances and Disease Registry	CY 2007	Effective	74
National Ctr for HIV, Viral Hepatitis, STD and TB Prevention	CY 2007	Effective	1002
National Institutes of Health:			
HIV / AIDS Research	CY 2003	Moderately Effective	2,913
Extramural Research Activities	CY 2004	Effective	22,044
Buildings and Facilities	CY 2005	Effective	127
Intramural Research	CY 2005	Effective	2,911
Extramural Construction	CY 2006	Moderately Effective	0
Extramural Research Training and Research Career Development	CY 2006	Effective	1,384
Substance Abuse and Mental Health Services Administration:			
Children's Mental Health Services	CY 2002	Moderately Effective	102
Projects for Assistance in Transition from Homelessness	CY 2002	Moderately Effective	53
Substance Abuse Treatment Prog. of Region. & Nation. Signif	CY 2002	Adequate	400
Mental Health Block Grant	CY 2003	Adequate	421
Substance Abuse Prevention & Treatment Block Grant	CY 2003	Ineffective	1,759
Substance Abuse Prevention Prog. of Region. & Nation. Signif	CY 2004	Moderately Effective	194
Mental Health Prog. of Region. & Nation. Signif	CY 2005	RND	299
Protection and Advocacy for Individuals with Mental Illness	CY 2005	Moderately Effective	35
Access to Recovery	CY 2007	Moderately Effective	96
Agency for Healthcare Research and Quality:			
Data Collection and Dissemination	CY 2002	Moderately Effective	63
Patient Safety	CY 2003	Adequate	79
Pharmaceutical Outcomes	CY 2004	Moderately Effective	43
Centers for Medicare & Medicaid Services:			
Medicare Integrity Program	CY 2002	Effective	756
Medicare Program	CY 2003	Moderately Effective	465,082
SCHIP	CY 2003	Adequate	7,600
Medicaid	CY 2006	Adequate	203,788
Administration for Children and Families:			
Refugee and Entrant Assistance: Soc. Serv	CY 2002	Adequate	154
Child Support Enforcement /1	CY 2003	Effective	4,211
Community Services Block Grant	CY 2003	RND	654
Developmental Disabilities	CY 2003	Adequate	163
LIHEAP	CY 2003	RND	2,570
Assets for Independence	CY 2004	Adequate	24
Child Care	CY 2004	Moderately Effective	4,979
Child Welfare: Child Abuse Prevnt. & Treatmnt. Act State Grant	CY 2004	RND	27
Child Welfare: Community-Based Child Abuse Prevention	CY 2004	RND	42
Child Welfare: Independent Living	CY 2004	RND	140
Violent Crime Reduction Programs	CY 2004	RND	123
Adoption Assistance	CY 2005	Moderately Effective	2,156
Adoption Incentives	CY 2005	Adequate	4
Adoption Opportunities	CY 2005	Adequate	26
Mentoring Children of Prisoners	CY 2005	RND	49
Refugee and Entrant Assistance: Transition & Medical Services	CY 2005	Effective	296
Social Services Block Grant	CY 2005	RND	1,700

HHS PARTed Programs (Dollars in Millions)

	PART Cycle	Narrative Rating	FY 2008 Enacted
Temporary Assistance for Needy Families	CY 2005	Moderately Effective	$17,059
Victims of Trafficking	CY 2005	Moderately Effective	10
Abstinence Education	CY 2006	Adequate	151
Child Welfare Services	CY 2006	Moderately Effective	282
Compassion Capital Fund	CY 2006	RND	53
Head Start	CY 2006	Moderately Effective	6,878
Promoting Safe and Stable Families	CY 2006	Moderately Effective	428
Runaway and Homeless Youth	CY 2006	Effective	96
Unaccompanied Alien Children	CY 2006	Adequate	133
Foster Care	CY 2007	Moderately Effective	4,581
Administration on Aging:			
Overall	CY 2007	Effective	1,417
Office of the Secretary:			
Bioterrorism Hospital Preparedness	CY 2003	RND	423
Adolescent and Family Life	CY 2004	RND	30
Women's Health	CY 2004	RND	31
Office of Disease Prevention and Health Promotion	CY 2005	RND	7
Office of Minority Health	CY 2005	RND	49
OGHA: US Mexico Border Health Commission	CY 2005	RND	4
Commissioned Corps: Readiness and Response Program	CY 2006	Adequate	16
Office of the National Coordinator	CY 2006	RND	61
Office of Medicare Hearings and Appeals	CY 2006	RND	64
OGHA: Afghanistan Health Initiative	CY 2007	Adequate	6
Minority HIV/AIDS Initiative	CY 2007	RND	51
Office for Civil Rights			
Office for Civil Rights	CY 2005	Moderately Effective	34
Office of Inspector General:			
Health Care Fraud and Abuse Control	CY 2002	RND	170
Multi-Agency PARTs /2			
CDC/ Department of State/United States Agency for International Development			
President's Emergency Plan for AIDS Relief /3			
Other Bilateral Programs /4	CY 2005	Adequate	119
Focus Countries /5	CY 2005	Moderately Effective	
HRSA/Department of Justice			
Vaccine Injury Compensation /6	CY 2005	Adequate	5

1/ Funding for Child Support Enforcement (CSE) reflects CSE-only obligations, which are a subcomponent of the CSE and Family Support Programs account. CSE-only obligations are a better proxy for the activities covered by this PART than account-level BA.

2/ Funding amounts in this table reflect HHS contributions only. See footnotes below for total multi-agency funding for each PART program.

3/ NIH provides transfer funding to the Global Fund to Fight AIDS, Tuberculosis, and Malaria. However, HHS did not participate in the PART review of the Global Fund. NIH funding levels:; FY 2008 enacted level is $295 M. Totals including other agency contributions: FY 2008 enacted level is $840.3 M.

4/ Total funding for Other Bilateral program includes other agency contributions: FY 2008 level is $1,021.3 M.

5/ CDC participated in this PART. However, funding is provided through the Foreign Operations appropriation bill. Totals including other agency contributions: FY 2008 level is $4,166 M.

6/ The total FY 2008 enacted level is $16.3 M.

Appendix 4: President's Management Agenda

HHS participates in five government-wide and four program-specific initiatives as part of the President's Management Agenda, with consistently high performance. The table below presents the Department's FY 2007 scorecard with a comparison to FY 2006. Overall, the Department finished FY 2007 with green progress ratings for six of the nine initiatives. HHS is committed to the President's Management Agenda goals and has made significant achievements on the scorecard relative to management excellence. For current ratings, and more information about the President's Management Agenda, visit www.results.gov.

It is noteworthy that during FY 2007, the status score for the "Eliminating Improper Payments" initiative improved from "red" to "yellow" as a result of establishing error measurement methodologies for each of HHS' high-risk programs. A report on the eliminating improper payment initiative, required by the Improper Payments Information Act of 2002, is presented in Section III of the FY 2007 Agency Financial Report, available at www.hhs.gov/afr/information/improper/index.html. A discussion of each initiative's progress during the past year can be found at www.hhs.gov/budget/09budget/2009BudgetInBrief.pdf.

President's Management Agenda Scorecard Results

		30-Sep-06		30-Sep-07	
Initiative Type	**Target Area**	**Status**	**Progress**	**Status**	**Progress**
Government-wide	Strategic Management of Human Capital	G	G	G	G
	Competitive Sourcing	G	G	G	G
	Improved Financial Performance	R	G	R	G
	Expanded Electronic Government	R	Y	Y	Y
	Performance Improvement (Renamed – Previously Budget & Performance Integration)	Y	G	R	Y
Program	Eliminating Improper Payments	R	G	Y	G
	Faith-Based and Community Initiative	G	G	G	Y
	Real Property Asset Management	Y	G	Y	G
	Health Information Quality & Transparency (New Initiative)	N/A	N/A	R	G

Green G Successful Results

Yellow Y Mixed Results

Red R Unsatisfactory Results

Appendix 5: Department Management Challenges and High-Risk Areas

The breadth of essential human services the Department delivers to fulfill the President's vision of a healthier, safer, and more hopeful America bring a number of management challenges. Management challenges identified by the Office of Inspector General (OIG) and its assessment of progress in addressing these challenges are described below. This information is from the OIG's Top Management Challenges, originally published on November 15, 2007 in Section III of the HHS FY 2007 Agency Financial Report, available online at www.hhs.gov/afr/information/challenges/index.html. To ensure good stewardship of taxpayer resources, the Department is committed to efforts to make improvements related to these challenges. In recent years, HHS has made significant strides in improving the lives of Americans. This has been accomplished through the efforts of every HHS component. While HHS has made great progress, it must continue its current efforts to sustain positive outcomes and augment them with new, innovative strategies to continue to improve the Nation's health and well-being.

Management Issue 1: Oversight of Medicare Part D

Management Challenge: The administration of Part D is dependent upon extensive coordination and information sharing among Federal and State Government agencies, drug plan sponsors, contractors, health care providers, and third party payers. CMS and drug plan sponsors share responsibility for protecting the Part D program from fraud, waste, and abuse. Payments to drug plan sponsors based on bids, risk adjustments, and reconciliations add to the complexities and challenges of the benefit. Preliminary estimates indicated that Part D sponsors owed Medicare more than $4 billion for plan year 2006, with 80 percent of sponsors owing money to Medicare. OIG also determined that CMS's safeguard activities needed further development and application.

Assessment of Progress: CMS has demonstrated progress in protecting Medicare Part D from fraud and abuse, but further implementation of safeguards is needed. CMS has noted several advances made in 2007 including progress towards commencing financial audits, commencement of routine Prescription Drug Plan (PDP) compliance audits, improvement in processing complaints timely, and updates to the Prescription Drug Benefit manual. CMS is also planning or implementing additional safeguard activities, including data monitoring, monitoring of compliance of drug plan sponsors, and education and guidance. Finally, CMS indicated that it anticipates that the variance between prospective and reconciled payments will decrease over time as program data becomes available to CMS and drug plan sponsors.

Management Issue 2: Integrity of Medicare Payments

Management Challenge: The size and scope of the Medicare program place it at high risk for payment errors. To ensure both the solvency of the Trust Fund and beneficiaries' continued access to quality services, correct and appropriate payments must be made for properly rendered services. OIG audits continue to show that Medicare has serious internal control weaknesses in its financial systems and processes. Further audits and evaluations by OIG also continue to identify significant improper payments and problems in specific parts of the program, such as durable medical equipment.

Assessment of Progress: The FY 2006 gross paid claims error rate of 4.4 percent reported by CMS is 0.8 percentage points lower than the FY 2005 error rate. CMS has demonstrated continued vigilance in monitoring the error rate and is developing appropriate corrective action plans. CMS has made some progress in its general and application controls, such as access controls, application software development controls, and program change controls and has begun implementing the Healthcare Integrated General Ledger Accounting System (HIGLAS), but the OIG's financial statement audit identified weaknesses in application controls at Medicare contractors, at data centers where Medicare claims are processed, at sites that maintain the "shared" application system software used in claims processing, and at the CMS central office. To address potential improper payment exposure for durable medical equipment, HHS announced a 2-year effort aimed at stopping fraudulent billing to the Medicare program and protecting beneficiaries and taxpayers.

Management Issue 3: Appropriateness of Medicaid and SCHIP Payments

Management Challenge: Medicaid is a joint Federal and State program that provides medical assistance to an estimated 50 million low income and disabled Americans. Because Medicaid and SCHIP are Federal/State matching programs, improper payments by States lead to corresponding improper Federal payments. Identifying payment errors and their causes in the Medicaid and SCHIP programs is particularly difficult because of the diversity of State programs and the variation in their administrative and control systems. Until recently, little was known about payment error rates in the Medicaid and SCHIP programs. This lack of information represented a substantial vulnerability in preventing fraud, waste, and abuse.

In addition, OIG has identified vulnerabilities in particular program areas such as prescription drugs. CMS estimates that Medicaid expenditures for prescription drugs in 2006 totaled more than $28 billion. OIG has consistently recommended that Medicaid programs reimburse pharmacies for drugs based on prices that more accurately reflect pharmacies' acquisition costs. OIG has also raised concerns that State Medicaid programs may not be receiving the proper amount of drug rebates that they are entitled to receive from drug manufacturers.

Assessment of Progress: *Payment Error Rates*: HHS' FY 2007 Performance and Accountability Report includes a preliminary national Medicaid fee-for-service error rate based on a sample of States and of claims within those States for the first two quarters of FY 2006. The final national Medicaid fee-for-service error rate for FY 2006 will be reported in the FY 2008 PAR, as will the national Medicaid and SCHIP fee-for-service, managed care and eligibility error rates for FY 2007. CMS expects to be fully compliant with the Improper Payments Information Act requirements by FY 2008.

Prescription Drugs. CMS has been directed by section 6001(f) of the DRA to conduct a monthly survey of retail prices for prescription drugs. This information is to be provided to the States monthly and compared to State payment rates annually. On July 17, 2007, CMS published in the Federal Register a final rule with comment period (72 FR 39142) that (1) implements the provisions of the DRA pertaining to prescription drugs under the Medicaid program, (2) adds to existing regulations Medicaid rebate policies, and (3) solicits public comments on the Federal upper limits outlier and average manufacturer price sections of the rule.

Management Issue 4: Medicaid Administration

Management Challenge: Over the past 6 years, OIG's work has identified significant problems in State Medicaid financing arrangements involving the use of intergovernmental transfers (IGT). Once payments are returned to State governments through IGTs, funds cannot be tracked and they may be used by the States for purposes unrelated to Medicaid. This practice shifts the cost of Medicaid to the Federal Government, contrary to Federal and State cost sharing principles. OIG has identified serious problems with IGTs in Medicaid supplemental payments to public hospitals and long term care facilities available under the upper payment limit (UPL) rules. Additionally, OIG has identified significant Federal overpayments involving school-based health services, disproportionate share hospital payments (DSH), and targeted case management services.

Assessment of Progress: To curb abuses in State Medicaid financing arrangements, CMS promulgated final regulations (effective March 13 and November 5, 2001, and May 14, 2002) that modified UPL regulations pursuant to the Benefits Improvement and Protection Act of 2000. CMS also has been working with States to stop the inappropriate use of IGTs. In addition, on May 29, 2007, CMS placed a Final Rule with Comment Period, CMS-2258-FC (Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership) on display at the Federal Register (May 29, 2007; 72 Fed.Reg. 29748) that would modify Medicaid reimbursement. CMS also is developing regulations to clarify policies regarding reimbursement for school-based transportation services and administrative costs, DSH payments, and targeted case management services.

Management Issue 5: Quality of Care

Management Challenge: Ensuring the quality of care provided to beneficiaries of Federal health care programs is a high priority of OIG. OIG has raised a number of concerns about shortcomings in program oversight and enforcement systems that may result in inadequate prevention or insufficient identification of the delivery of substandard care in a variety of health care settings. Some of these concerns include vulnerabilities associated with fragmentation of care, Quality Improvement Organization (QIO) monitoring, and hospice oversight.

Assessment of Progress: CMS plans to increase monitoring of quality-of-care problems associated with consecutive stays and is working with providers to improve care for Medicare beneficiaries regardless of where care is provided. CMS is also requiring the QIO to categorize complaints to better provided data on lapses in care continuity with emphasis on improved documentation. Additionally, CMS has included hospices in the annual State Performance Standards System that measures State performance in survey and certification activities.

Management Issue 6: Public Health Emergency Preparedness and Response

Management Challenge: Events, such as the terrorist attacks of September 11, 2001; the 2005 Gulf Coast hurricanes; and the potential for future public health emergencies, such as the threat of pandemic influenza, continue to underscore the importance of having a comprehensive national public health infrastructure that is prepared to rapidly respond to public health emergencies. Recent OIG work has shown that, although some progress had been made, the States and localities are still generally under prepared.

Assessment of Progress: States and localities are making progress in strengthening their bioterrorism preparedness programs. Federal, State, and local health departments are striving to work cooperatively to ensure that potential bioterrorist attacks are detected early and responded to appropriately. CDC has taken steps to improve its capacity to detect and respond to harmful agents and to expand the availability of pharmaceuticals needed in the event of chemical, biological, or radiological attacks. Both CDC and ASPR have updated their Public Health and Hospital Preparedness Cooperative Agreements to incorporate stronger performance measures and clearer guidance for grant recipients. CDC also plans to implement automated data entry in laboratories, establish a forum for information sharing, as well as identify additional technical resources to increase State and local capacity to respond to a potential terrorist threat. CMS is exploring ways to strengthen Federal certification standards for nursing home emergency preparedness and to promote better coordination among Federal, State, and local emergency management entities. Additionally, the Office of the Surgeon General, Office of Public Health and Science, is implementing many of OIG's recommendations related to the Commissioned Corps, including identifying, rostering, training, and equipping designated response teams of Commissioned Corps officers.

Management Issue 7: Oversight of Food, Drug, and Medical Device Safety

Management Challenge: Given their critical public health oversight mandates, NIH and FDA must have in place policies and programs that ensure the integrity of medical research endeavors, protect human research subjects, provide for pre-approval and post-approval monitoring of regulated medical products and treatments, and ensure the safety of the nation's food supply. OIG audits and evaluations have consistently documented weaknesses in the Department's oversight system for protecting human research subjects in clinical trials associated with NIH grants and those conducted by manufacturers seeking FDA approval for regulated products. Recent work has also identified weaknesses in FDA's monitoring of drugs following their approval for marketing. Recent food contamination incidents have highlighted the importance ensuring the safety of our nation's food supply.

Assessment of Progress: HHS has implemented many changes to protect human research subjects and to strengthen FDA and NIH oversight of scientific research. In June of 2006, FDA announced a Human Subject Protection/Bioresearch Monitoring initiative, published a proposed rule for the creation of an institutional review board registry, released several draft guidance documents that addressed various bioresearch monitoring topics, and is developing an internal listing of all ongoing clinical trials. FDA has

also contracted a study to assess and provide recommendations concerning quality improvements to the post-marketing study commitments process. Additionally, FDA is implementing provisions of the Public Health Security and Bioterrorism Response Act of 2002, related to the processing and distribution of food products.

Management Issue 8: Grants Management

Management Challenge: In FY 2008, the Department expects to issue grants totaling $270 billion ($38 billion discretionary and $232 billion mandatory). Grants management remains a challenge because of the very nature of a grant. A grant is financial assistance for an approved activity with performance responsibility resting primarily on the grantee, with little or no Government involvement in the funded activity. Inadequate grant oversight and monitoring continues to be a concern of OIG.

Assessment of Progress: Through the government-wide Federal Grant Streamlining Program, the HHS grants management environment is continually undergoing significant changes. The program is intended to implement the Federal Financial Assistance Management Improvement Act of 1999 (Public Law 106-107), which requires agencies to improve the effectiveness and performance of their grant programs, simplify the grant application and reporting process, improve the delivery of services to the public, and increase communication among entities responsible for delivering services.

Management Issue 9: Integrity of Information Technology Systems and Infrastructure

Management Challenge: In 2001, the President identified the development and implementation of an "interoperable health information technology infrastructure" as a key initiative. To facilitate this, in April 2004, the President issued Executive Order 13335, which established the position of the National Health Information Technology Coordinator (National Coordinator) and outlined incentives for the use of health information technology. The development and expansion of Department IT systems brings new focus to additional areas of risk. For instance, over the past several years, the importance of protecting personal data has become much more visible. OIG has also identified that the human factor is a critical component of an effective security program and may be overlooked in the development of technical solutions to address weaknesses in entity wide security, access controls, service continuity, application controls and development, and segregation of duties.

Assessment of Progress: HHS has made progress in the security of the Department's most critical and essential assets, both physical and cyber based, such as laboratories, computer systems, and data communication networks. The Secure One HHS project, begun in FY 2003 and supported through a multiyear contract, was initiated by the Department to improve IT security from the top down by providing security policy, procedures, and guidance to HHS agencies.

Management Issue 10: Ethics Program Oversight and Enforcement

Management Challenge: In recent years, OIG has devoted considerable efforts to ensuring the effectiveness in the administration of the Department's ethics program and to investigations related to violations of the criminal ethics statute. Pursuant to regulations issued by the Office of Government Ethics, the Secretary has delegated responsibility for the day-to-day administration of the ethics program to the Designated Ethics Official (DAEO). OIG has identified vulnerabilities in NIH and FDA's processes for review and approval of outside activities and in the Department's issuance of conflict-of-interest waivers, and continues to be concerned about potential conflicts of interest relating to members of scientific advisory panels and grantees of research funding.

Assessment of Progress: The heightened focus on ethics in the Department has brought about significant changes. NIH convened a Blue Ribbon Panel appointed by the NIH Director. The Department's Supplemental Standards of Ethical Conduct were revised in 2005, adding prohibitions on outside activities and financial holdings for certain employees at NIH. The revised standards also imposed a more detailed process for reviewing outside activity requests department-wide. The staff of the DAEO, housed in the OGC Ethics Division, was expanded and ethics staff are reaching out on a monthly basis to ethics contacts for each OPDIV and Staff Division. The DAEO is also taking steps to tighten up the waiver process.

Appendix 6: Other Sources of Information

Listed below are references and internet links to comprehensive, publicly available information about HHS' program and financial performance.

HHS-wide Resources

FY 2009 HHS Budget in Brief: The Budget in Brief summarizes the HHS portion of the FY 2009 President's Budget request to Congress. http://www.hhs.gov/budget/09budget/2009BudgetInBrief.pdf

FY 2009 Congressional Justifications: These Congressional Justifications present the FY 2009 President's Budget for HHS. www.hhs.gov/budget/docbudget.htm

Online Performance Appendix: The Online Performance Appendix supplements the performance information included in the FY 2009 Congressional Justifications from HHS agencies, and provides a detailed performance plan for FY 2009. It also serves as a performance report for data that became available in the past year. www.hhs.gov/budget/docbudget.htm

The HHS Office of Budget Website: The website for the HHS Office of Budget provides information on the Department's budget from FY 2000 through FY 2009. www.hhs.gov/budget/docbudget.htm

Agency Financial Report: The FY 2007 HHS Agency Financial Report provides HHS financial statements for FY 2007. www.hhs.gov/afr/index.html

Past Performance and Accountability Reports: The FY 2000 – FY 2006 HHS Performance and Accountability Reports provide performance and financial information and an assessment of the Department's accomplishments for the relevant fiscal year. www.hhs.gov/of/reports/account/index.html

HHS Strategic Plan - FY 2007 – FY 2012: This HHS Strategic Plan establishes four broad goals that represent the HHS mission and encompass its central functions. www.aspe.hhs.gov/hhsplan/2007/

Health People 2010: Healthy People 2010 challenges individuals, communities, and professionals to take specific steps to ensure that good health, as well as long life, are enjoyed by all. www.healthypeople.gov/

HHS Agency Websites

The mission of each HHS agency is provided in Appendix 1. Links to each HHS agency's website are available at: www.hhs.gov/about/index.html

Federal Government Resources

Expect More.gov: Detailed information on programs assessed by the Program Assessment Rating Tool (PART) are available at: www.ExpectMore.gov