U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES

STRATEGIC PLAN

FISCAL YEARS 2007-2012

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"I appreciate the hard work and dedication that more than 67,000 employees throughout the HHS family of agencies have shown in advancing the Department's initiatives this year, and I look forward to working together to continue meeting expectations for the present and the challenges of the future."

Michael O. Leavitt
Secretary of Health and Human Services

Secretary's Message

The President of the United States has given me a very clear mission: to help Americans live longer, healthier, and better lives, and to do it in a way that protects our economic competitiveness as a Nation.

To meet this charge, the *HHS Strategic Plan, Fiscal Years 2007–2012 (Strategic Plan),* will address health care; public health promotion and protection, disease prevention, and emergency preparedness; human services; and scientific research and development over the next 5 years. These broad goals represent the mission of the U.S. Department of Health and Human Services (HHS) and encompass its central functions.

Health Care – At some point in our lives, every one of us is or will become a health care consumer. HHS's strategic objectives focus on increasing the value of health care by measuring quality and cost in a standardized and comparable way, broadening access to health insurance coverage and access to health care, and investing in the health care industry infrastructure and personnel. These efforts will provide better health care at lower cost for more Americans.

Public Health Promotion and Protection, Disease Prevention, and Emergency Preparedness – Events such as Hurricane Katrina and the attacks of September 11, 2001, are reminders that HHS must be prepared to respond efficiently and effectively to a natural or manmade public health disaster. At the same time, chronic and infectious diseases claim hundreds of thousands of lives in this country each year. Efforts to improve and protect public health range from a focus on healthy lifestyles, immunizations, food safety, and health literacy to developing planning tools and building stockpiles of medicine and supplies to respond to an outbreak of pandemic influenza.

Human Services – The economic and social well-being of individuals, families, and communities is fundamental to human dignity and a healthy life. HHS is dedicated to encouraging the development of healthy and supportive families and communities and to promoting economic independence and social well-being across the lifespan. HHS is particularly committed to ensuring the safety, stability, and healthy development of the Nation's children and youth.

Scientific Research and Development – In order to continue leading the world in cutting-edge science and medicine, HHS must invest in the expansion of scientific knowledge and the pool of qualified researchers. Today, Americans have an unparalleled opportunity to attain more personalized health care through the marvels of modern science. HHS will continue to provide educational grants, training, and fellowship programs and to fund research and clinical trials that are ethical and have the potential to improve public health and well-being.

This *Strategic Plan* lays out the action steps that HHS will take to meet the President's vision for a stronger, healthier United States. I appreciate the hard work and dedication that more than 67,000 employees throughout the HHS family of agencies have shown in advancing the Department's initiatives this year, and I look forward to working together to continue meeting expectations for the present and the challenges of the future.

Michael O. Leavitt
Secretary
Health and Human Services

"The economic and social well-being of individuals, families and communities is fundamental to human dignity and a healthy life."

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Secretary, Health and Human Services

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The Strategic Plan encompasses the major areas of focus for HHS at the goal level and lays out the primary strategies for achieving these goals.

Executive Summary

Healthy and productive individuals, families, and communities are the foundation of the Nation's present and future security and prosperity. Through leadership in the medical sciences and public health and human service programs, the U.S. Department of Health and Human Services (HHS) seeks to improve the health and well-being of people in this country and throughout the world.

Since HHS submitted its last strategic plan to the U.S. Congress in 2004, HHS has made significant strides in improving the lives of Americans. HHS has made progress through the efforts of every HHS operating and staff division. Breakthroughs in health information technology have accelerated the development and adoption of this promising resource. Medicare beneficiaries have greater access to their medications because of the Medicare prescription drug benefit. Medicaid can tailor benefits to needs because its modernization efforts have made the program more flexible and sustainable. HHS deployed medical supplies and Federal Medical Shelters from the Strategic National Stockpile to help with mass casualty care needed after Hurricanes Katrina and Rita. The newly created Drug Safety Oversight Board has provided independent recommendations related to drug safety to the Food and Drug Administration and shared information with health care professionals and patients. The HHS Compassion Capital Fund has strengthened the capacity of grassroots, faith-based, and community organizations to provide a wide range of social services. Advances in the understanding of basic human biology enabled sequencing of the human genome 2 years ahead of schedule.

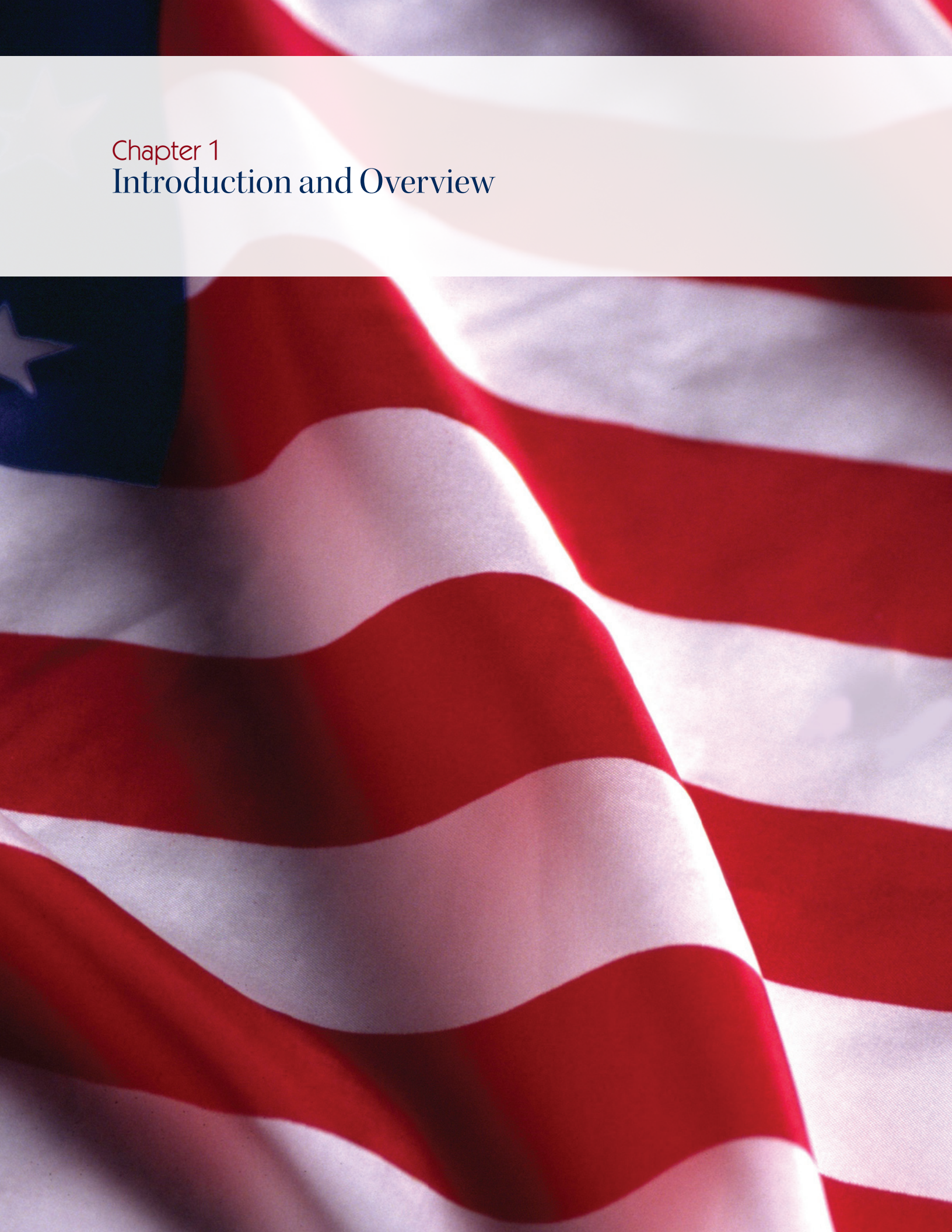
Although HHS has made great progress, it must continue its current efforts to sustain positive outcomes and augment them with new, innovative strategies to continue to improve the Nation's health and well-being. At the same time, HHS must work diligently to address emerging and reemerging health threats. These include a possible influenza pandemic; the rise of drug-resistant strains of tuberculosis and HIV; and potential terrorist attacks involving chemical, biological, radiological, and nuclear agents.

The *HHS Strategic Plan, Fiscal Years 2007–2012 (Strategic Plan),* provides direction for HHS efforts to improve the health and well-being of the Nation. The *Strategic Plan's* goals and objectives direct HHS efforts to improve health care, promote and protect the public's health, enhance human services, and advance the research and development enterprise. The *Strategic Plan* also addresses emerging threats to the health and well-being of Americans.

The *Strategic Plan* encompasses the major areas of focus for HHS at the goal level and lays out the primary strategies for achieving these goals. However, it does not include all actions that HHS might take to achieve any one objective. Given the size and breadth of HHS and its programs, it would be impractical to provide a comprehensive list of all HHS-supported strategies and activities. Strategic objectives are not meant to be a catalog of all potential implementation plans; they merely indicate the priorities and general direction HHS intends to take.

Chapter 1

Introduction and Overview



Mission

The HHS mission is to enhance the health and well-being of Americans by providing for effective health and human services and by fostering sound, sustained advances in the sciences underlying medicine, public health, and social services.

Core Principles[1]

The Secretary has developed core public policy principles, which serve as the basis for the Department's efforts toward achieving its mission. These principles of governance form the philosophical backbone for how HHS approaches and solves problems. The nine principles, listed to the right, are not all inclusive, but they do provide the philosophical underpinnings for this *Strategic Plan,* and they will be incorporated into other planning documents used by HHS.

CORE PRINCIPLES

- National standards, neighborhood solutions.
- Collaboration, not polarization.
- Solutions transcend political boundaries.
- Markets before mandates.
- Protect privacy.
- Science for facts, process for priorities.
- Reward results, not programs.
- Change a heart, change a nation.
- Value life.

Organization

Eleven operating divisions, including eight agencies in the United States Public Health Service (USPHS) and three human service agencies, administer HHS's programs. Eighteen staff divisions provide leadership, direction, and policy and management guidance to the Department. (A complete list of HHS's operating and staff divisions and a brief description of their activities appear in Appendix F.) HHS works closely with State, local, and tribal governments, and many HHS-funded services are provided at the local level by State, county, local, or tribal agencies, or through grantees in the private sector, including faith-based and community-based organizations.

HHS accomplishes its mission through more than 300 programs and initiatives that cover a wide spectrum of activities, including the following:

- Providing Medicare (health insurance for Americans who are 65 or older, who are disabled, or who suffer from end stage renal disease) and Medicaid (health insurance for low-income people);
- Assuring the safety of food and medical products;
- Delivering comprehensive health care for Native Americans;
- Promoting access to insurance for the uninsured and necessary health services for medically underserved individuals;
- Creating an environment that supports the use of health information technologies;
- Preventing disease through immunization;
- Promoting healthy lifestyles;
- Promoting healthy dietary practices, good nutrition, and regular physical activity;
- Improving the oversight of imported food and medical products;
- Supporting the prevention and treatment of substance abuse;
- Improving maternal and infant health;
- Planning and preparing for public health emergencies, including those that result from terrorism;
- Providing Head Start (preschool education and services);
- Preventing child abuse and domestic violence;
- Supporting faith-based and community initiatives;
- Improving systems of services in communities to enhance the health and well-being of children and youth with special health care needs and their families;
- Providing financial assistance and services for low-income families;
- Offering services for older Americans, including home-delivered meals;
- Furthering access to health and human services by protecting health information privacy and preventing discrimination in the delivery of these services; and
- Conducting, supporting, and overseeing scientific and biomedical research and development related to health and human services.

With an FY 2007 budget of $698 billion, HHS represents almost a quarter of all Federal expenditures and administers more grant dollars than all other Federal agencies combined. More than 67,000 people work for HHS.[II] Every 3 years, HHS updates its strategic plan, which describes its operating and staff divisions that work individually and collectively to address complex, multifaceted, and ever-evolving health and human service issues.

Developing and Updating the Strategic Plan

An agency strategic plan is one of three main elements required by the Government Performance and Results Act (GPRA) of 1993 (Public Law 103-62). The basic requirements for strategic plans appear in the Office of Management and Budget (OMB) Circular No. A-11, Part 6, Section 210. According to OMB, "an agency's strategic plan keys on those programs and activities that carry out the agency's mission. Strategic plans will provide the overarching framework for an agency's performance budget."[III]

In constructing the *Strategic Plan*, HHS sought to respond to the requirements of both GPRA and OMB. At the same time, HHS incorporated priorities and concepts from the Secretary's 500-Day Plan, the Secretary's Ten Health Care Priority Activities, the

Departmental Objectives, and the *Healthy People 2010* Objectives. Although some of these plans and priorities may change from year to year, the most recent versions appear later in this chapter, in a special section called *In the Spotlight: HHS Plans and Priorities*.

Each of the Department's operating and staff divisions contributed to the development of this *Strategic Plan*, from the goals and the broad strategic objectives to the baselines and targets for performance indicators. Representatives from HHS operating and staff divisions provided expert knowledge of HHS's programs, initiatives, priorities, and performance indicators. This process emphasized creating alignment between the long-range *Strategic Plan* and annual GPRA reporting in the HHS Annual Performance Plan, Annual Performance Budgets, and Performance and Accountability Report. More information about this alignment appears in Appendix C, *Performance Plan Linkage*.

In developing and selecting performance indicators, HHS sought to include broad health and human service impact measures as well as more intermediate processes and outcomes that have contributed to distal impacts. In several cases, numerous operating and staff divisions play a role in achieving these impacts. Operational and staff division personnel regularly monitor thousands of additional performance indicators to improve program processes and examine effectiveness. However, in this *Strategic Plan*, HHS focused on a limited set of broad outcomes and impacts to demonstrate Departmental progress.

Consultation

HHS regularly consults with external stakeholders, as noted in Chapters 2 through 5. In complying with OMB guidance and GPRA, HHS consulted widely with stakeholders to garner input on the *Strategic Plan*. HHS posted a draft on its Web site (http://www.hhs.gov), invited public comment through a notice in the Federal Register, and briefed a number of State, local, and tribal organizations. HHS also sought input from the U.S. Congress and OMB.

During its consultation process, HHS received correspondence from more than 40 individuals or organizations, containing nearly 200 unique suggestions. Input ranged from editorial to more substantive comments. HHS has incorporated many of these changes and additions to the final plan.

Structure

Chapters 2 through 5 present the four strategic goal areas:

- *Health Care.* Promote access to insurance for the uninsured and necessary health services for individuals who are medically underserved;
- *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;
- *Human Services.* Promote the economic and social well-being of individuals, families, and communities; and
- *Scientific Research and Development.* Advance scientific and biomedical research and development related to health and human services.

Chapter 2 focuses on the *Health Care* strategic goal. It highlights the efforts of HHS to improve the safety, quality, affordability, and accessibility of health care, including behavioral health care and long-term care. HHS's Administration on Aging (AoA), Agency for Healthcare Research and Quality (AHRQ), Centers for Medicare & Medicaid Services (CMS), Health Resources and Services Administration (HRSA), and the Indian Health Service (IHS) have a significant role to play in realizing this goal. In addition, HHS's Food and Drug Administration (FDA), Office of the Assistant Secretary for Planning and Evaluation (ASPE), Office for Civil Rights (OCR), Office on Disability (OD), Office of Public Health and Science (OPHS), and Substance Abuse and Mental Health Services Administration (SAMHSA) play roles in addressing this goal.

There are four broad strategic objectives under *Health Care:*

- Broaden health insurance and long-term care coverage;
- Increase health care service availability and accessibility;
- Improve health care quality, safety, cost, and value; and
- Recruit, develop, and retain a competent health care workforce.

This chapter also highlights two sections of particular significance to HHS in the area of health care, both now and over the next 5 years:

- *In the Spotlight: Reducing Health Disparities* gives a brief overview of disparities that still exist in America and outlines the HHS response to combat these disparities.
- *In the Spotlight: Advancing the Development and Use of Health Information Technology* provides a brief but indepth explanation of the efforts HHS will be undertaking to promote the use of this important tool.

Chapter 3 explains the strategic goal of *Public Health Promotion and Protection, Disease Prevention, and Emergency Preparedness.* This chapter outlines the steps that HHS will take to prevent and control disease, injury, illness, and disability across the lifespan and to protect the public from the health consequences of infectious, occupational, environmental, and terrorist threats. Key operating and staff divisions that contribute to this goal include the Centers for Disease Control and Prevention (CDC), FDA, HRSA, Office of the National Coordinator for Health Information Technology (ONC), Office of the Assistant Secretary for Preparedness and Response (ASPR), and SAMHSA. In addition, AoA, CMS, OCR, OD, the Office of Global Health Affairs (OGHA), and OPHS play roles in addressing this goal.

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

- Prevent the spread of infectious diseases;
- Protect the public against injuries and environmental threats;

- Promote and encourage preventive health care, including mental health, lifelong healthy behaviors, and recovery; and
- Prepare for and respond to natural and manmade disasters.

This chapter also features two significant public health efforts HHS is undertaking and will continue to develop over the next 5 years:

- *In the Spotlight: Emergency Preparedness, Prevention, and Response* explains how HHS will prepare for and respond to public health and medical emergencies.
- *In the Spotlight: Global Health Initiatives* explains the strategies to promote health and public health beyond our own borders.

Chapter 4 details the *Human Services* strategic goal. This goal seeks to protect and value life, family, and human dignity by promoting the economic and social well-being of individuals, families, and communities; supporting the safety and well-being of children, youth, older people, and other vulnerable populations; and strengthening communities. The Administration for Children and Families (ACF), AoA, the Center for Faith-Based and Community Initiatives (CFBCI), and OD are among the divisions primarily responsible for achieving this strategic goal. In addition, CDC, HRSA, OCR, OPHS, and SAMHSA play important roles.

There are four broad objectives under *Human Services:*

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

This chapter also discusses how a changing America will impact HHS's efforts and strategies in the coming years. *In the Spotlight: Demographic Changes and Their Impact on Health and Well-Being* explains how HHS is working to meet the health, public health, and human service needs of a population that will grow older and increasingly diverse in the next 5 years.

HHS's commitment to *Scientific Research and Development* appears in Chapter 5. The chapter outlines efforts to advance scientific and biomedical research and development related to health and human services. This strategic goal will be achieved through the contributions of AHRQ, CDC, FDA, OPHS and, most significantly, the National Institutes of Health (NIH).

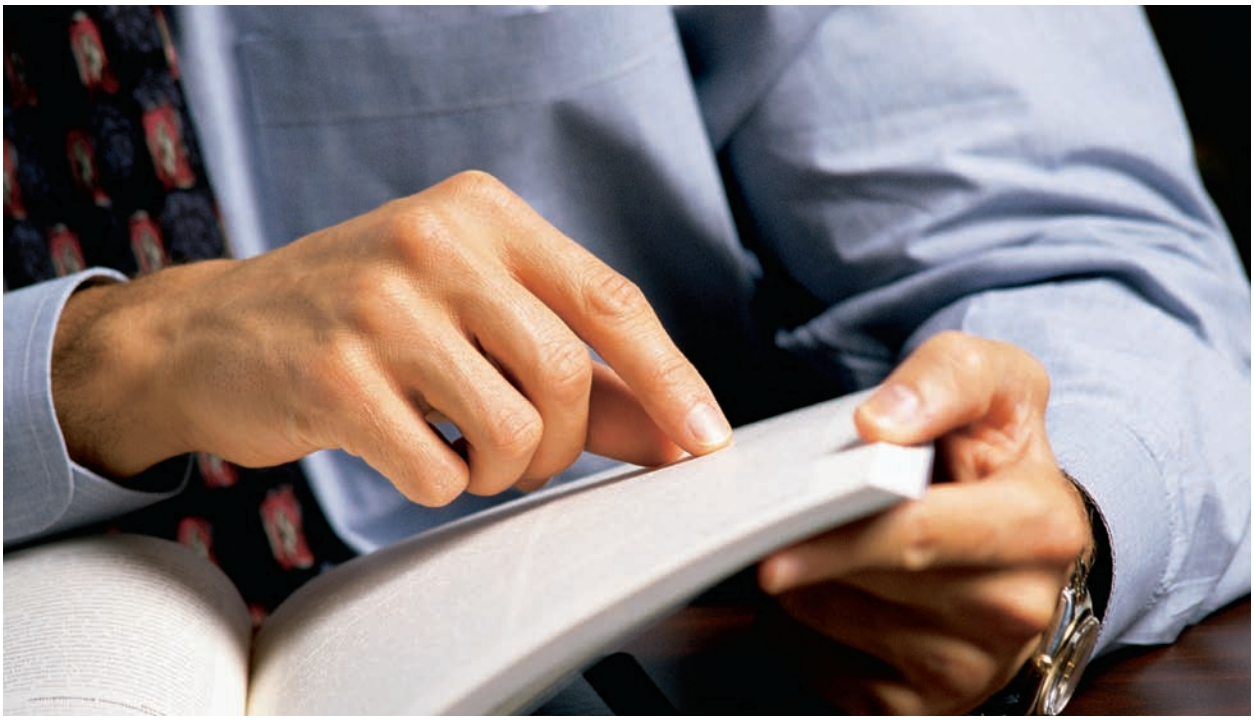
There are four broad objectives under *Scientific Research and Development:*

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

Chapters 2 through 5 describe how HHS will accomplish the goals and measure their achievement:

- *Strategic objectives* for each broad goal organize the activities into four distinct areas of focus. In most cases, several HHS operating and staff divisions contribute to the realization of a strategic objective;
- *Narrative sections*, organized by strategic objective, illustrate some of the major strategies and activities undertaken by HHS operating and staff divisions. These sections present key intradepartmental and interdepartmental coordination efforts;
- *Specific performance indicators* for each objective are listed, with baselines and 2012 targets. Appendix B provides a list of the data sources for these performance indicators; and
- *External influences* that affect successful achievement of the goals, and HHS's strategies in response to these influences, are described.

Chapter 6, *Responsible Stewardship and Effective Management,* illustrates the commitment of HHS to formulate, implement, and execute efficient administrative support for its programs. These activities do not appear as goals in the *Strategic*



Plan because they are not intended to be separate from the overall management process that supports the Department. The chapter details strategies for effective management of human capital, information technology, and resources, as well as effective planning, oversight, and strategic communications.

Finally, appendixes provide additional specific information about supporting materials related to the *Strategic Plan*.

HHS conducts high-quality program evaluations to learn more about the effectiveness of its interventions and uses the findings to improve program performance. These comprehensive, independent studies are an important component of the HHS strategy to improve overall effectiveness by assessing whether programs are effective, well designed, and well managed. Appendix A, *HHS Program Evaluation Efforts,* describes how HHS has used program evaluations to develop the *Strategic Plan*. This appendix offers examples of existing and planned program evaluations that will inform decisions and activities over the next 5 years.

Appendix B, *Performance Indicators—Supplemental Information,* lists the data sources for each of the performance indicators listed in the *Strategic Plan*, as well as fiscal year information for baselines and targets. This information is presented by strategic goal.

Appendix C, *Performance Plan Linkage,* describes how the *Strategic Plan* will drive the Annual Performance Plan and Annual Performance Budgets, as well as how it will complement Secretarial priorities.

Because of the rapid changes in computer technology in recent years, HHS has included an additional section focused on this issue. Appendix D, *Information Technology,* details HHS's enterprise and information architecture strategies and presents insights on innovations and future trends. Unlike *In the Spotlight: Advancing the Development and Use of Health Information Technology,* which focuses on the use of this resource to support the public, this appendix focuses on how HHS uses this resource internally.

Finally, several appendixes offer useful reference material for readers: The HHS organizational chart is in Appendix E; Appendix F consists of an overview of HHS operating and staff divisions and their primary functions; Appendix G lists acronyms used throughout the *Strategic Plan;* and endnotes are listed in Appendix H.

This *Strategic Plan for FY 2007–2012* incorporates priorities and concepts from the Secretary's 500-Day Plan, the Secretary's Ten Health Care Priority Activities, the Departmental Objectives, and the *Healthy People 2010* Objectives. Although some of these plans and priorities may change from year to year, a sampling of the most recent versions is included here.

Secretary's 500-Day Plan

Secretary Leavitt uses a 500-Day Plan, updated every 200 days, as a management tool to guide his energies in fulfilling the vision of a healthier and more hopeful America. The Secretary focuses on specific strategies that will achieve significant progress for the American people over a 5,000-day horizon. The 500-Day Plan supports the *Strategic Plan* in guiding the Department in achieving its broad policy and program objectives. The priorities include:

- Transform the Health Care System;
- Modernize Medicare and Medicaid;
- Advance Medical Research;
- Secure the Homeland;
- Protect Life, Family, and Human Dignity; and
- Improve the Human Condition Around the World.

Secretary's Health Care Priorities

In 2006, the Secretary developed 10 HHS Priority Activities for America's Health Care; these too are updated annually:

- Health Care Value Incentives;
- Health Information Technology;
- Medicare Rx;
- Medicaid Modernization;
- New Orleans Health System;
- Personalized Health Care;
- Obesity Prevention;
- Pandemic Preparedness;
- Emergency Response and Commissioned Corps Renewal; and
- International Health Diplomacy.

Departmental Objectives

Last updated in 2006, 20 Departmentwide objectives express the breadth and scope of the Department's activities. Updated annually, they expand on the Secretary's goals from the 500-Day Plan and include objectives related to effective management and responsible stewardship:

1. Accelerate Personalized Health Care;
2. Recruit, Develop, Retain, and Strategically Manage a World-Class HHS Workforce;
3. Modernize Medicaid;
4. Continue Our Leadership Role and Success in Competitive Sourcing;
5. Turn Adversity to Advantage for the New Orleans Health System;
6. Improve Financial Performance;
7. Promote Health Information Technology;
8. Expand Electronic Government;
9. Continue to Improve Medicare;
10. Improve Budget and Performance Integration;
11. Harness the Power of Transparent Health Care;
12. Implement the Real Property Asset Management Program and Strategically Manage Our Real Property;
13. Emphasize Prevention and Healthy Living;
14. Broaden Health Insurance and Long-Term Care Coverage;
15. Prepare for an Influenza Pandemic;
16. Promote Quality, Relevance, and Performance of Research and Development Activities;
17. Enhance Emergency Response and Renew the Commissioned Corps;
18. Improve the Service of Management Functions and Administrative Operations for the Support of the Department's Mission;
19. Emphasize Faith-Based and Community Solutions; and
20. Eliminate Improper Payments.

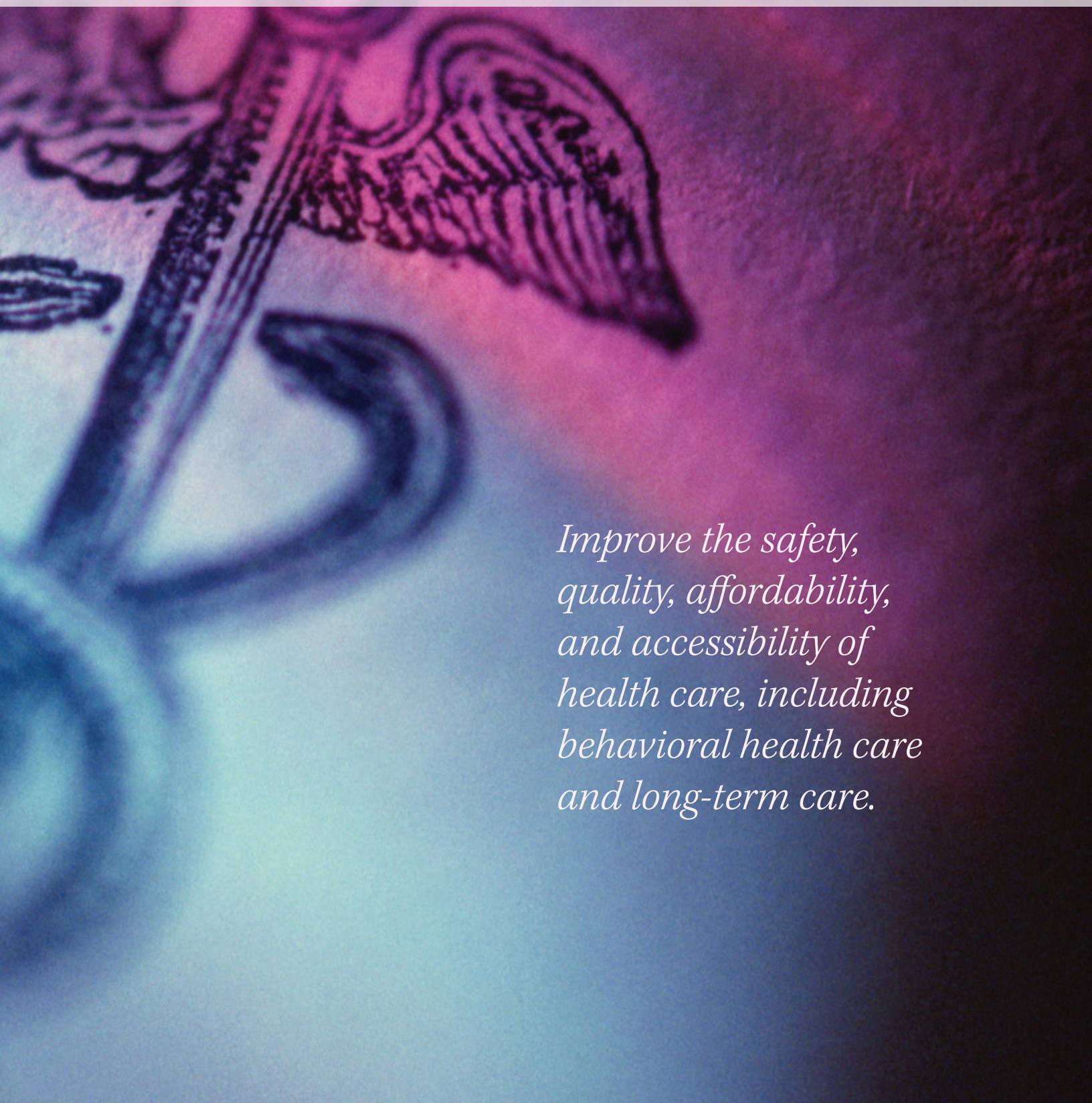
Healthy People 2010

Healthy People 2010 is a comprehensive set of disease prevention and health promotion objectives for the Nation to achieve over the first decade of the new century. Overarching goals are to increase quality and years of healthy life and eliminate health disparities. There are 28 focus areas:

- Access to Quality Health Services;
- Arthritis, Osteoporosis, and Chronic Back Conditions;
- Cancer;
- Chronic Kidney Disease;
- Diabetes;
- Disability and Secondary Conditions;
- Educational and Community-Based Programs;
- Environmental Health;
- Family Planning;
- Food Safety;
- Health Communication;
- Heart Disease and Stroke;
- HIV;
- Immunization and Infectious Diseases;
- Injury and Violence Prevention;
- Maternal, Infant, and Child Health;
- Medical Product Safety;
- Mental Health and Mental Disorders;
- Nutrition and Overweight;
- Occupational Safety and Health;
- Oral Health;
- Physical Activity and Fitness;
- Public Health Infrastructure;
- Respiratory Diseases;
- Sexually Transmitted Diseases;
- Substance Abuse;
- Tobacco Use; and
- Vision and Hearing.

Chapter 2
Strategic Goal 1:

Health Care



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

The system needs to make progress in providing the excellent quality of care that all Americans deserve.

Today, disease, illness, and disability can be as much a threat to Americans' financial well-being as they are to Americans' physical and mental well-being. Every American deserves reliable, high-quality, and reasonably priced health care that will be there when it is needed. Health care has to be available, affordable, portable, transparent, and efficient.

Health care in the United States is second to none, but it can be better. Although our Nation's health care facilities and medical professionals are the best in the world, improving quality, constraining costs, and providing greater access remain key priorities.

Americans spend an increasing share of their income on health care. Health care spending in America has increased from 5 percent of Gross Domestic Product (GDP) in 1960 to more than 16 percent in 2006, and is predicted to continue to rise.[IV] The increasing burden of health spending on the U.S. economy is unsustainable. Higher spending on public programs such as Medicare and Medicaid strains Federal and State budgets. Higher insurance premiums burden workers with higher health costs and pose a challenge for employers to cover both wage increases and health insurance premiums.

STRATEGIC GOAL 1: HEALTH CARE

Strategic Objective 1.1:

Broaden health insurance and long-term care coverage.

Strategic Objective 1.2:

Increase health care service availability and accessibility.

Strategic Objective 1.3:

Improve health care quality, safety, cost and value.

Strategic Objective 1.4:

Recruit, develop and retain a competent health care workforce.

The system needs to make progress in providing the excellent quality of care that all Americans deserve. We need to increase the rate at which patients receive recommended services and to reduce the number of unnecessary services. We also must eliminate preventable medical errors.

Forty-six million Americans do not have health insurance.[v] 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 in the future.

One critical part of HHS's strategy to address these problems is to improve transparency within the health care system. Because third parties such as insurance companies, employers, and governments finance the vast majority of health care spending, most Americans do not know—and do not have access to information about—the cost and quality of health care services in order to decide whether they want to receive those services.

Making health care affordable, accessible, and high quality depends on providing consumers with the knowledge they need to make informed choices about their health care coverage. The Federal Government must lead in accomplishing these objectives. We are encouraged that others in the private sector have joined in such efforts; we will continue to pursue these goals, which characterize a value-driven health care system.

The increasing costs of health care services, our increasingly older population with multiple chronic conditions, and an increasingly complex health care system challenge us to continue our efforts to develop new strategies to maintain safe and affordable services designed to meet Americans' needs in their various income, family, and health circumstances. HHS is working to improve the efficiency and quality of health care that it finances and delivers. Promoting greater use of health information technology will ensure that accurate and timely information on a patient's condition is available to all providers involved in the patient's care and will reduce unnecessarily redundant diagnostic tests and office visits that add to health care costs. Implementation of value-based purchasing systems that include incentives to providers for treatment outcomes, rather than just reimbursements for treatments, will again help move the system toward more efficient and cost-effective provision of care aimed at improving the health and quality of life of the citizens touched by HHS programs.

At the same time, we must ensure that our efforts to reduce the cost of high-quality health care are reflected in more affordable and accessible health insurance coverage, to address the problem of the Nation's growing number of citizens without health insurance. HHS continues to explore options for increasing the portability and accessibility of health insurance through innovative vehicles such as Health Savings Accounts coupled with high-deductible health plans, which have grown in popularity in recent years. Additionally, HHS is working to increase access to private health insurance for those who do not yet have it through initiatives such as *Affordable Choices*. Together, these initiatives will assist individuals in maintaining their health and prevent health spending from overburdening the economy.

Finally, the need to rebuild the health care infrastructure in New Orleans in the wake of Hurricane Katrina offers the Department and its State and local partners the challenge of coordinating coverage; system capacity; and workforce recruitment, retention, and development in new ways that result in a revitalized health care system for that community.

Strategic Goal 1, *Health Care,* targets the need for people to be able to obtain and maintain affordable health care coverage; receive efficient, high-quality health care services; and access appropriate information for informed choices. HHS's Administration on Aging (AoA), Agency for Healthcare Research and Quality (AHRQ), Centers for Medicare & Medicaid Services (CMS), Health Resources and Services Administration (HRSA), and Indian Health Service (IHS) have significant roles to play in realizing this goal. In addition, the Food and Drug Administration (FDA), Office of the Assistant Secretary for Planning and Evaluation (ASPE), Office for Civil Rights (OCR), Office on Disability (OD), Office of Public

Health and Science (OPHS), and Substance Abuse and Mental Health Services Administration (SAMHSA) play roles in addressing this goal.

There are four broad objectives under *Health Care:*

- Broaden health insurance and long-term care coverage;
- Increase health care service availability and accessibility;
- Improve health care quality, safety, cost, and value; and
- Recruit, develop, and retain a competent health care workforce.

Below is a description of each strategic objective, followed by a description of the key programs, services, and initiatives the Department is undertaking to accomplish those objectives. Key partners and collaborative efforts are included under each relevant objective. The performance indicators selected for this strategic goal also are presented with baselines and targets. These measures are organized by objective. Finally, this chapter discusses the major external factors that will influence HHS's ability to achieve these objectives, and how the Department is working to mitigate those factors.

Strategic Objective 1.1

Broaden health insurance and long-term care coverage.

HHS is committed to broadening health insurance and long-term care coverage. The multifaceted approach to expanding consumer choices includes strengthening and expanding the safety net through programs such as Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP); creating new, affordable health insurance options; and creating new options for long-term care, including State Long-Term Care Partnership Programs. The operating and staff divisions contributing to the achievement of this objective include CMS, SAMHSA, AoA, HRSA, and OD.

The growing availability of prescription drugs and their cost have had a significant impact on health insurance. The first selected performance indicator, at the end of this chapter, measures the percentage of Medicare beneficiaries who have insurance coverage for prescription drugs through the Medicare drug benefit (Part D) or other coverage. This enrollment is expected to increase. Also, health care coverage for millions of present and future Medicare participants is protected by ensuring that the level of improper payments in the Medicare Fee-For-Service program remains low.

Health Insurance
Medicare

Medicare is a health insurance program for people age 65 years or older, people younger than age 65 with serious disabilities, and most people of all ages with end stage renal disease (permanent kidney failure requiring dialysis or a kidney transplant). Three major categories of Medicare include: Part A, which covers inpatient hospital care, skilled nursing facilities, certain home health care, and hospice care; Part B, which encompasses physicians' services, outpatient hospital care, and many other medical services; and Part D, the newest component of Medicare, which offers a voluntary prescription drug benefit to beneficiaries. There is also a Part C for Medicare, known as Medicare Advantage, that allows beneficiaries to choose a private health insurance plan that covers the Part A and Part B services and, in most circumstances, additional benefits and/or lower cost-sharing payments than under the traditional Medicare FFS program.

Medicare Part D. Part D is celebrated as the most significant improvement to the program since Medicare was created in 1965. More than 39 million Medicare beneficiaries now have prescription drug coverage through Part D or another source, including almost 24 million beneficiaries in Part D plans.[vi] CMS continues to improve program administration of the Medicare prescription drug benefit and to expand awareness of the program through relationships with States and pharmacists, increased use of electronic technology, and education and outreach efforts with more than sixteen thousand partners. CMS will continue these efforts to ensure that beneficiaries can get the prescriptions they need. In particular, CMS has collaborated with AoA and its grassroots *Aging Services Network,* consisting of State agencies on aging, area agencies on aging, and local service providers, to provide one-on-one assistance and outreach directly to beneficiaries and their caregivers.

A number of other initiatives to broaden access are currently underway or in development, such as the *"My Health. My Medicare."* campaign and *Medicare Medical Savings Accounts.*

The *"My Health. My Medicare."* campaign helps people with Medicare maximize their understanding of the benefits Medicare offers. CMS promotes beneficiary awareness through mailings, media activities, a strong Internet presence, a 24-hour-a-day toll-free telephone service, grassroots alliances, and enhanced beneficiary counseling with State Health Insurance Assistance Programs. CMS partners in this effort include the National Medicare Education Program Partnership Alliance, AoA and its *Aging Services Network,* State and local agencies, grassroots organizations, the AARP,[1] Medicare Today, the National Caucus and Center on Black Aged, national disability provider and constituent organizations, and other stakeholders. CMS continues to build committed partnerships at the community level; these partnerships will ensure the agency can successfully build on the *"My Health. My Medicare."* campaign, as well as other health-related initiatives, in future years. These partnerships are having a profound impact on helping CMS reach the Medicare population, especially the program's most vulnerable beneficiaries. For example, in collaboration with AoA, in addition to working with the general Medicare population, special efforts are being made to target minority populations to reduce health disparities in the Hispanic, Asian, and African-American communities, as well as in rural communities.

Medicare Medical Savings Accounts. CMS is implementing an enhanced consumer-directed Medicare Advantage product called a Medicare Medical Savings Account (MSA) plan. This type of plan combines a high-deductible health plan with a medical savings account that beneficiaries can use to manage their health care costs. CMS will offer regular MSA plans and new demonstration MSA plans. These plans will provide Medicare beneficiaries with the freedom to exercise increased control over their health care utilization while providing them with important coverage against catastrophic health care costs. CMS is providing increased flexibility with the demonstration MSA plans to make the MSAs more like the popular consumer-directed Health Savings Accounts (HSAs) available in the private sector. Examples of the types of flexibility being made available under the demonstration that are not available under the regular MSA rules include coverage of preventive services during the deductible period, a deductible below an out-of-pocket maximum, cost sharing up to the out-of-pocket maximum, and cost differentials between in- and out-of-network services.

Medicaid

Medicaid is a joint Federal- and State-funded, State-administered health insurance program available to certain low-income individuals and families who fit into an eligibility group that is recognized by Federal and State law. Using a variety of State plan options and waivers, each State establishes its own rules and guidelines regarding eligibility and service offerings, subject to approval by CMS.

CMS also offers flexible State plan options and community-living incentives. In support of these options and incentives, CMS and AoA will continue to target home- and community-based long-term care services to frail older adults who are at high risk of nursing home placement or at risk of spending down their assets. SAMHSA and CMS also will continue to collaborate on issues regarding Medicaid coverage for substance abuse and mental health services.

Children's Health Insurance

The State Children's Health Insurance Program (SCHIP), a State-administered program, addresses the growing problem of children without health insurance. SCHIP was designed as a Federal-State partnership, similar to Medicaid, with the goal of expanding health insurance to children whose families earn too much money to be eligible for Medicaid, but not enough money to purchase private insurance. CMS will work

1 According to its Web site, in November 1998 the American Association for Retired Persons officially changed its name to AARP.

with the U.S. Congress to reauthorize SCHIP to ensure that these vital programs continue.

Affordable Choices

HHS has begun to work with other Federal departments and with States to increase access to private health insurance for those who do not yet have it through the *Affordable Choices* initiative and related efforts. This proposal would redirect inefficient institutional subsidies to individuals and would need to be State based and budget neutral, not create a new entitlement, and not affect savings contained in the President's Budget that are necessary to address the unsustainable growth of Federal entitlement programs.

Outreach To Raise Awareness

Health Insurance Enrollment and Long-Term Care Coverage Outreach is a collaboration of CMS, AoA, ACF, HRSA, State and local health departments, State Medicaid and SCHIP agencies, State and area agencies on aging, child care and early education providers, and State departments of agriculture and education. This collaborative effort conducts outreach to raise awareness of public health insurance and long-term care benefits and provides information and access assistance.

Demonstrations and Waivers

States have many options, including Federal waivers, for broadening coverage to underserved populations. Using Health Insurance Flexibility and Accountability waivers, States can develop comprehensive insurance coverage for individuals at twice the Federal Poverty Level (FPL) and below, using SCHIP and Medicaid funds. These waiver programs target vulnerable, uninsured populations, such as children on Medicaid and SCHIP, and pregnant women. Emphasis is placed on broad statewide approaches that maximize both private health insurance coverage and employer-sponsored insurance.

Indian Health Programs

IHS provides a comprehensive health services delivery system for American Indians and Alaska Natives with opportunity for maximum tribal involvement in developing and managing programs to meet their health needs. The mission of IHS, in partnership with American Indian and Alaska Native (AI/AN) people, is to raise their physical, mental, social, and spiritual health to the highest level. The goal of IHS is to ensure that comprehensive, culturally acceptable personal and public health services are available and accessible to all American Indians and Alaska Natives. IHS promotes healthy AI/AN people, communities, and cultures and honors the inherent sovereign rights of tribes as part of the Federal Government's special relationship through treaty obligations with tribes.

In 2005, IHS provided health services to approximately 1.5 million American Indians and Alaska Natives who belong to more than 557 federally recognized tribes in 35 States.[vii] Both primary care physicians and nurse practitioners provide primary care.[viii] Those children or adults in fair or poor health with only IHS coverage probably did not see a physician in the past year. Adults in good or excellent health with only IHS coverage were probably less likely to have seen a physician in the past 2 years, compared to similar adults with Medicaid or private insurance.[ix] IHS access alone does not constitute health insurance coverage. Those not served by IHS may use private or State insurance out of preference or lack of proximity to IHS or tribal facilities. Limitation of contracted health service funds and insurance reduces the use of specialty care physician services for American Indians and Alaska Natives.

In response to these and other emerging challenges, IHS is focused on expanding access for American Indians and Alaska Natives to comprehensive primary health care services. In addition, IHS recognizes the importance of retinopathy screening for those with diabetes and colorectal screening for early cancer detection and prevention. CMS has joined in efforts to expand access for American Indians and Alaska Natives to health care services covered by Medicare, Medicaid,

and SCHIP. The Indian Health Care Improvement Act of 1976 (Public Law 94-437), as amended, extended the Federal obligation to CMS by authorizing payment for Medicare and Medicaid services provided through IHS facilities. This responsibility includes services provided by tribal governments administering health programs under authorities through the Indian Self-Determination and Education Assistance Act of 1975 (Public Law 93-638), as amended. The Indian Health Care Improvement Act further expanded this responsibility by authorizing 100 percent Federal Medical Assistance Percentage to States for payments to IHS and tribal facilities for Medicaid services. CMS works with IHS and the tribes to ensure they follow the *Payor of Last Resort* rule. According to this rule, IHS pays after Medicare or Medicaid has paid for eligible services, whether IHS and tribes provide services directly or a private source provides them under referred services.

Long-Term Care

Long-term care can be required by individuals with disabilities needing assistance with activities of daily living, individuals with frailty and/or dementia associated with aging, individuals with advanced chronic conditions, and other individuals at or near the end of life. The central vision for an efficient long-term care system is one that is person centered, i.e., organized around the needs of the individual rather than around the settings where care is delivered. The evolving long-term care system of the future will provide coordinated, high-quality care; optimize choice and independence; be served by an adequate workforce; be transparent, encouraging personal responsibility; be financially sustainable; and utilize health information technology to improve access and quality of care.

In an effort to facilitate this system transformation, CMS, in partnership with the U.S. Congress, provides funding to States, territories, and tribal entities to expand choices to persons who need long-term care services. *Real Choice Systems Change* grants, *Medicaid Infrastructure* grants, and *Systems Transformation* grants are a few examples of HHS efforts to assist States in building the needed infrastructure for expanding choices.

HHS also works closely with States, territories, and tribal entities to achieve more flexibility in the Medicaid program. To that end, the *Money Follows the Person Rebalancing Demonstration* project builds on the President's *New Freedom* initiative.[2]

The *Money Follows the Person Rebalancing Demonstration* project will help States further address the institutional bias in coverage inherent in the Medicaid program. Selected States will be awarded additional Federal funds to pay for home- and community-based services for the first year that individuals transition from institutional care to a community-based setting of their choice.

The *Long-Term Care Insurance Partnership Program* is a federally supported, State-operated initiative that allows individuals who purchase a qualified long-term care insurance policy to protect a portion of their assets that they would typically need to spend down prior to qualifying for Medicaid coverage. Once individuals purchase a long-term care insurance partnership policy and use some or all of their policy benefits, the amount of the policy benefits used will be disregarded for purposes of calculating eligibility for Medicaid. This stipulation means that they are able to keep their assets up to the amount of the policy benefits they purchased and used. For example, in a State that chooses to participate in the partnership program, once individuals have used part or all of their maximum lifetime benefit under their long-term care insurance coverage, their assets would be protected up to the amount used, up to that maximum lifetime benefit. Individuals would not need to spend those assets before qualifying for that State's Medicaid program.

The *Aging and Disability Resource Center* grant program, a cooperative effort between CMS and AoA, assists States with their efforts to streamline access to long-term care. Program funding supports the development of "one-stop

2 The *New Freedom* initiative eliminates the barriers that prevent people with disabilities from participating fully in community life. It provides a comprehensive, Governmentwide framework for achieving that goal.

shop" programs to serve as a single, coordinated system of information, assistance, and access. Persons seeking knowledge about long-term care will receive information that will minimize confusion, enhance individual choice, and support informed decisionmaking. Persons seeking knowledge about public and private long-term care options will receive information that will minimize confusion, enhance individual choice, and support informed decisionmaking.

Building on this effort, AoA's *Choices for Independence* demonstration project aims to provide seniors and their caregivers with information, assistance, and counseling to confront the difficult decisions they face regarding long-term independence in the community, by seeking to reduce the current systemic bias in favor of institutional care. *Choices for Independence* will target people while they are still healthy and able to plan for their care and will encourage them to take positive steps to maintain their own health. If people need care, *Choices for Independence* will help them to bolster their own support system and resources before they enter a nursing home and spend down to Medicaid.

CMS is working with ASPE and AoA on the HHS *Own Your Future* campaign, in partnership with six States (Georgia, Massachusetts, Michigan, Nebraska, South Dakota, and Texas). *Own Your Future* is an aggressive education and outreach effort designed to increase consumer awareness about planning for long-term care. The campaign uses Federal-State partnerships to help individuals from ages 45 to 65 take an active role in planning by evaluating their future long-term needs and resources. *Own Your Future* provides objective information and resources to help individuals and their families plan for future long-term care needs.

To enhance this effort, AoA, ASPE, and CMS have launched the *National Clearinghouse for Long-Term Care Information* Web site to increase public awareness about the risks and costs of long-term care and the potential need for services.

CMS is working with the U.S. Department of Housing and Urban Development to explore options for the provision of long-term care services for beneficiaries living in affordable housing. ASPE and AoA are also collaborating on strategies to develop reverse mortgage programs that will encourage homeowners to use existing assets to acquire long-term care services in the community. CMS is also collaborating with AoA, ASPE, the Administration on Developmental Disabilities (ADD) in HHS's Administration for Children and Families (ACF), OD, and Federal agencies such as the U.S. Departments of Education and Labor to address long-term care workforce issues.

Strategic Objective 1.2

Increase health care service availability and accessibility.

In addition to broadening health care and long-term care coverage, HHS is committed to increasing the availability and accessibility of health care services. This commitment includes reaching out to vulnerable and underserved populations, such as American Indians and Alaska Natives, people with disabilities, and rural populations. In addition, the Department is committed to enhancing and expanding existing services, such as health centers, long-term care options, substance abuse and mental health treatment programs, and Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) programs. Among the operating and staff divisions contributing to the achievement of this objective are AoA, CMS, HRSA, IHS, OCR, OD, ONC, OPHS, and SAMHSA.

Selected HHS performance indicators that best capture the impact of the wide array of HHS services provided under this strategic objective follow:

- Key aspects of having regular access to a source of ongoing care for the entire population;
- Receipt of services by American Indians and Alaska Natives, with whom HHS has a special treaty relationship;
- Efforts to expand access to publicly funded health centers and substance abuse treatment programs; and
- Rates at which programs funded by Title XXVI of the Public Health Service Act as amended by the Ryan White HIV/AIDS Treatment Modernization Act (Ryan White HIV/AIDS Program) serve racial and ethnic minorities, disproportionately affected by HIV/AIDS.

The joint planning initiative, *Empower Consumer Access to Health Care, Long-Term Care, and Behavioral Health Services,* is responsible for development, implementation, and coordination of health care, long-term care, and behavioral health service policies and programs. Ten HHS divisions partner with the U.S. Departments of Agriculture, Education, and Interior, as well as with State and local health departments, Medicaid and SCHIP State agencies, State and area

agencies on aging, child care providers, early education providers, and tribal governments.

American Indians and Alaska Natives

Health services are provided to American Indians and Alaska Natives through several means. In FY 2006, IHS provided health care services directly at 33 hospitals, 59 health centers, and 50 health stations and supports essential sanitation facilities (including water supply, sewage, and solid waste disposal) for American Indian/Alaska Native (AI/AN) homes and communities. IHS professional staff include approximately 2,700 nurses, 900 physicians, 400 engineers, 500 pharmacists, 300 dentists, and 150 sanitarians. IHS also employs various allied health professionals, such as nutritionists, health administrators, and medical records administrators. More than half of the IHS budget is now used to provide funding for American Indian Tribes, tribal organizations, and Alaska Native corporations that choose to contract or compact with IHS to provide health care under the Indian Self-Determination and Education Assistance Act of 1975 (Public Law 93-638), as amended. These entities administer 15 hospitals, 221 health centers, 9 residential treatment centers, 97 health stations, and 176 Alaska village clinics. Both IHS and tribal entities purchase additional health care services from private providers.[x]

HHS and the U.S. Department of Veterans Affairs (VA) have entered into a Memorandum of Understanding to encourage cooperation and resource sharing between IHS and the Veterans Health Administration. The goal is to use the expertise of both organizations to deliver quality health care services and enhance the health status of AI/AN veterans. An interagency advisory committee, involving IHS and the Office of Minority Health (OMH) in OPHS, identifies health disparities for American Indians and Alaska Natives compared to the general U.S. population.

People With Disabilities

The four goals included in *The Surgeon General's Call to Action to Improve the Health and Wellness of Persons with Disabilities* are as follows:

- Increase understanding nationwide that people with disabilities can lead long, healthy, and productive lives;
- Increase knowledge among health care professionals and provide them with tools to screen, diagnose, and treat the whole person with a disability with dignity;
- Increase awareness among people with disabilities of the steps they can take to develop and maintain a healthy lifestyle; and
- Increase accessible health care and support services to promote independence for people with disabilities.

Virtually every HHS operating and staff division has initiatives to support this critical effort, headed by OPHS's Office of the Surgeon General (OSG) and OD. Moreover, a broad array of Federal agencies, including the U.S. Departments of Agriculture, Defense, Education, Housing and Urban Development, Interior, Justice, Labor, Veterans Affairs, and the National Science Foundation, the Office of National Drug Control Policy, and the Social Security Administration, as well as many non-Federal stakeholders, have committed to pursuing these goals.

Of particular note is HRSA's effort to provide health and community resource information and peer support to families having children and youth with special health care needs. *Family-to-Family Health Information Centers,* funded under the Dylan Lee James Family Opportunity Act,[3] will be family-run, statewide centers in every State and the District of Columbia and will be responsible for developing partnerships with those organizations serving these children and their families. They also will be charged with monitoring the progress of programs with responsibility for payment and direct services of this population through a statewide data collection system.

3 The Dylan Lee James Family Opportunity Act was passed as a provision to the Deficit Reduction Act of 2005 (Public Law 109-171).

Rural Health

Through collaborative initiatives such as the HHS *Rural Task Force* and the *National Advisory Committee on Rural Health and Human Services*, HHS works to address the difficulties of providing health care in rural communities. A technical assistance Web site and targeted dissemination of information about innovative models for health services delivery in rural communities are part of HHS's overall strategy.

The *HHS Underserved Populations* effort focuses on delivery of health care services for underserved populations in rural and urban areas and involves CMS, HRSA, IHS, OD, SAMHSA, State and local health departments, health care providers, and the Tribal Technical Advisory Group.

Health Centers

At the beginning of FY 2007, HRSA's *Consolidated Health Center Program* was providing comprehensive primary and preventive health care in more than 3,800 sites across the country to an estimated 14.8 million people.[xi] Most Health Center patients have incomes at or below 200 percent of the FPL. Many Health Center patients have no health insurance, and most patients are racial or ethnic minorities.

Health Centers help to improve the availability of health services by providing a range of essential services. As new or expanded sites are funded in medically underserved communities, a major focus will be on poor rural and urban counties consistent with the President's goal of establishing new Health Centers in the poorest counties in the Nation. Health Centers help to improve the availability of health services by providing a range of essential services, including pharmacy services onsite or by paid referral, preventive dental care, and mental health and substance abuse services at most centers.

Mental Health

The final report of the *President's New Freedom Commission on Mental Health* (2003) called for a fundamental transformation of how mental health care is delivered in America. SAMHSA's Center for Mental Health Services will continue to work to transform the mental health system so that Americans understand that mental health is essential to overall health; mental health care is consumer and family driven; disparities in mental health services are eliminated; early mental health screening, assessment, and referral to services are common practice; excellent mental health care is delivered and research is accelerated; and technology is used to help consumers access mental health care and information.

New Orleans Health System

Hurricane Katrina incapacitated the Greater New Orleans health care system, ravaged its health care infrastructure, and severely impacted health care delivery in a number of Louisiana parishes. Eighty percent of New Orleans Health Centers were destroyed; the teaching hospitals of New Orleans were devastated; and countless people lost all of their medical records.

The Louisiana Health Care Redesign Collaborative strives to build an efficient 21st century health care system implementing technology, transparency, emergency preparedness, and greater personal health care choices. HHS is supporting the Collaborative in its effort by helping to convene stakeholders, providing expert assistance and other HHS resources, removing barriers to progress, and reviewing Medicaid waiver and Medicare demonstration concepts submitted by the Louisiana Health Care Redesign Collaborative in accordance with the guiding principles.

The goal is to improve health care by providing every citizen with access to health care that is prevention centered, neighborhood located, and electronically connected. Health care providers could use electronic health records and meet certain quality measures in order to provide care. Success means that Louisiana and New Orleans will have health care systems that can serve as models for the Nation. More information about how HHS is promoting electronic health records is included later in this chapter in, *In the Spotlight: Advancing the Development and Use of Health Information Technology*.

Ryan White HIV/AIDS Program

HRSA's programs through the Ryan White HIV/AIDS Program currently provide services to approximately 531,000 individuals who have little or no insurance and are impacted by HIV/AIDS.[xii] Key pieces of this program include its efforts to prioritize lifesaving services, medications, and primary care for individuals living with HIV/AIDS. Providing more flexibility to target resources to areas that have the greatest needs is also a key piece of the Ryan White HIV/AIDS Program. The program also encourages the participation of any provider, including faith-based and other community organizations, that shows results, recognizes the need for State and local planning, and ensures accountability by measuring progress.

Substance Abuse Services

SAMHSA's Center for Substance Abuse Treatment promotes the quality and availability of community-based substance abuse treatment services for individuals and families who need them. The Center for Substance Abuse Treatment works with States and community-based groups to improve and expand existing substance abuse treatment services under the Substance Abuse Prevention and Treatment Block Grant Program. The Center also supports SAMHSA's free treatment referral service to link people with the community-based substance abuse services they need.

Among SAMHSA's efforts to improve the health of the Nation by increasing access to effective alcohol and drug treatment is the *Access to Recovery* program. *Access to Recovery* is designed to accomplish three main objectives: to expand capacity by increasing the number and types of providers, including faith-based and community providers, who deliver clinical treatment and/or recovery support services; to require grantees to manage performance, based on patient outcomes; and to allow recovery to be pursued through many different and personal pathways. Vouchers, State flexibility, and executive discretion combine to create profound positive change in substance abuse treatment financing and service delivery. The innovative and unique *Access to Recovery* program is focused on consumer empowerment.

Under *Access to Recovery,* consumers will continue to have the ability to choose the path that is personally best for them and to choose the provider that best meets their needs, whether physical, mental, emotional, or spiritual.

Nondiscrimination and Privacy Protection

OCR ensures compliance with the nondiscrimination requirements of Title VI of the Civil Rights Act of 1964 (Public Law 88-352), as amended, requiring recipients of HHS Federal financial assistance to ensure that their policies and procedures do not exclude or limit, or have the effect of excluding or limiting, the participation of beneficiaries on the basis of race, color, or national origin. These efforts, which reach beneficiaries of all health and human service programs that HHS funds, seek to achieve voluntary compliance and corrective efforts when violations are found. OCR has collaborated with the U.S. Departments of Agriculture and Justice to produce a video and informational brochure in multiple languages to advise service providers and consumers with limited English proficiency about their responsibilities and rights under Title VI. OCR also enforces the federal privacy protections for individually identifiable health information provided by the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. Privacy enforcement activities provide consumer confidence in the confidentiality of their health information so that privacy concerns are not a deterrent to accessing care and full and accurate information is provided at treatment and payment encounters.

OCR will continue to work with Federal and State partners and with providers and consumer groups, including faith-based and community organizations, to ensure nondiscriminatory access to health and human services, to eliminate health disparities, and to protect the privacy of identifiable health information.

Strategic Objective 1.3

Improve health care quality, safety, cost, and value.

In the future, American health care will be shaped into a system in which doctors and hospitals succeed by providing the best value for their patients. Value in health care means delivering the right health care to the right person, at the right time, for the right price. Providing reliable health care cost and quality information can empower consumer choice at all levels. Systemwide improvements can occur as providers and payers can track how their practice, service, or plan compares to others. As value in health care becomes transparent to consumers and providers alike, HHS anticipates the following benefits: Costs will stabilize; more people will acquire insurance; more people will get access to better health care; and economic competitiveness will be preserved. Ultimately, this is a prescription for a value-driven system—a prescription of good medicine that works for everyone. HHS will work to achieve this value-based system over the next 5 years.

Several HHS operating and staff divisions contribute to this goal of improving the quality, safety, cost and, ultimately, the value of health care, including AHRQ, AoA, CMS, FDA, HRSA, IHS, NIH, ONC, OPHS, and SAMHSA.

The performance indicators for this strategic objective, listed in full at the end of this chapter, measure:

- Adoption of electronic health care records, which affect the long-term quality, value, and safety of health care;
- Quality of care that residents receive in nursing home facilities; and
- Number of States implementing specific approaches to improve the quality of Medicaid-funded health care, on which many low-income people depend.

Health Care Transparency

Health care transparency may restrain the growth of health care costs because consumers will know the comparative costs and quality of their health care—and they will have a financial incentive to seek out quality care at the lowest cost. Consumers will gain control of their health care and have the knowledge to make informed decisions. Health care transparency is built on four interconnected cornerstones:

- *Connect the System.* Every medical provider has a system for keeping health records. Increasingly, those systems are electronic. Standards need to be identified so that all health information systems can quickly and securely communicate and exchange data.
- *Measure and Publish Data on Quality.* Every case, every procedure, has an outcome. Some outcomes are better than others are. To measure quality, HHS must work with doctors and hospitals to define benchmarks for what constitutes quality care.
- *Measure and Publish Data on Price.* Price information is useless unless cost is calculated for identical services. Agreement is needed on what procedures and services are covered in each "episode of care."
- *Create Positive Incentives.* All parties—providers, patients, insurance companies, and payers—should participate in arrangements that reward both those who offer and those who purchase high-quality, competitively priced health care.

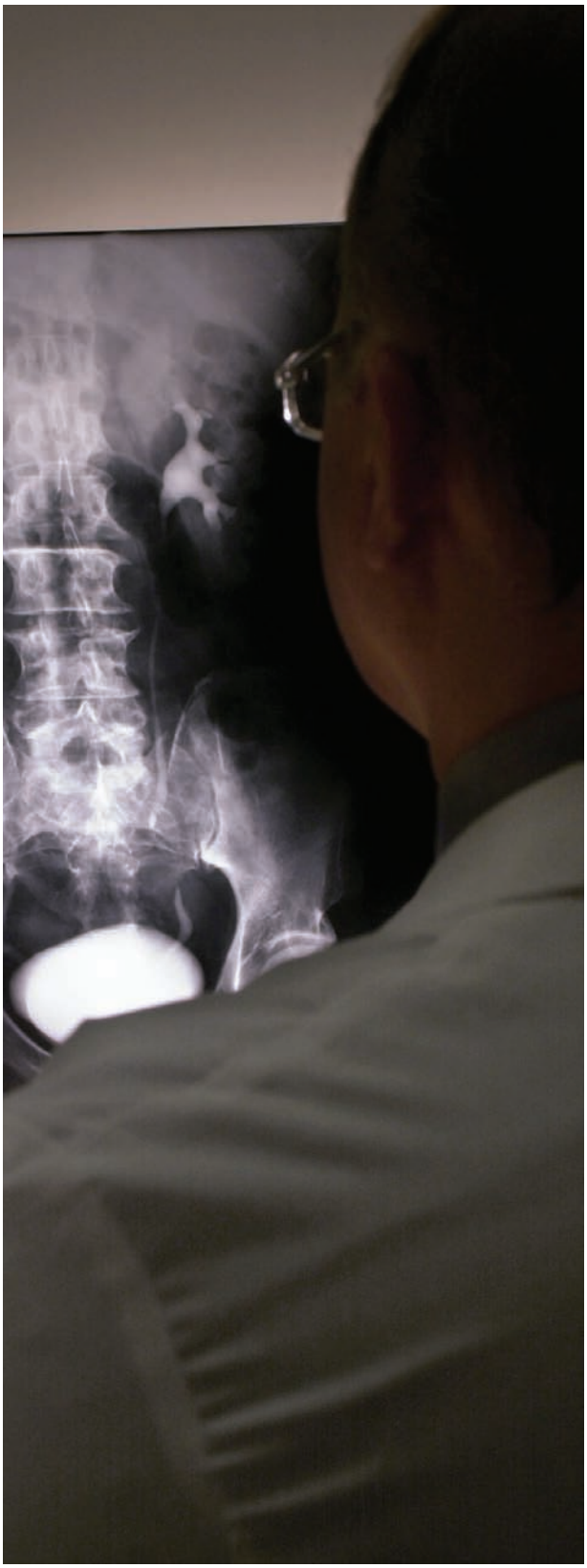
Employers committing to these cornerstones would agree to collect quality and price information through its health plan or benefit administrator, using the consensus standards. Employers committing to the goals also would be encouraged to share quality and price information with regional collaboratives, where information from many sources could be aggregated, thus producing the most broad-based and reliable information possible. The employer or its health plan would share quality information with enrollees and would provide specific costs the enrollee would expect to pay under the plan.

Six pilot programs to demonstrate how transparency can promote improvements in health care are underway, with support from CMS and AHRQ. These pilot programs are being coordinated under the *Better Quality Information Data Aggregation and Reporting* project, through a contract with the Maryland Medicare Quality Improvement Organization. The communities were selected using a set of criteria by a representative committee of the public/private entity *Ambulatory Care Quality Alliance*, which consists of 135 physician organizations, consumers, employers, and health plan representatives. The Alliance makes available quality information about physician care. The purpose is to measure and report on physician practice in a meaningful and transparent way for consumers and purchasers of health care.

Personalized Health Care

The future of health care in America is one in which care will be personalized, predictive, preemptive, and participatory. Advances in basic research have positioned us to begin to harness new and increasingly affordable potential in medical and scientific technology. With clinical tools that are increasingly targeted to the individual, our health care system can give consumers and providers the means to make more informed, individualized, and effective choices. Emphasis on personalized health care could make health care safer and more effective for every patient, especially when we are able to use the power of genetic information and health information technology to better understand each patient's needs and more precisely target therapies. This may mean that the same medical condition requires different treatment for men and women, or for older persons, or for others whose inherited traits may put them at particular risk.

Ongoing activities across HHS are working toward the long-term goals of personalized health care, and the convergence of these efforts will act as a powerful force to educate both the patient and the health care provider to improve clinical outcomes. Basic research at NIH is improving the foundational knowledge of diseases; FDA's *Critical Path Initiative* is improving the speed and safety of product development; and CDC will use population data to understand the genetic basis of diseases.



FDA has initiated the *Critical Path to Personalized Medicine*, a program designed to modernize and ensure more efficient development and clinical use of medical products. Under the *Critical Path Initiative*, HHS anticipates being able to dramatically increase the success rate in providing patients with innovative solutions that strike an optimal balance of high benefit and low risk because they are "personalized." Once both the disease and the person are understood at the molecular level, physicians will be able to provide treatment options uniquely suited to a patient's particular needs.

Electronic Health Records

Patients cannot receive appropriate and efficient care unless clinical information about them is available at the point of care. When patients' health information is not accessible to providers as they transition through the continuum of care, clinical decisions often must be made without full knowledge of patients' history and health status. The absence of needed clinical information can lead to a requirement to duplicate tests that not only increase the costs of health care, but also subject patients to unneeded clinical interventions that always carry a degree of risk. Similarly, the absence of needed information could lead to incorrect decisions or medical errors that could result in adverse clinical outcomes. Over time, more advanced electronic health records will have integrated clinical decision support with the latest scientific evidence guiding clinical interventions at the point of care along with environmental data that should also influence many treatment decisions. Increasing the adoption of interoperable electronic health records will decrease these risks to both the efficiency and efficacy of care. Through the collaborative activities of the American Health Information Community, chaired by the Secretary of HHS, much work is underway to identify the functionality and standards that will support the development and adoption of interoperable electronic health records to achieve the President's vision of making electronic health records available to most Americans by 2014.

More information about this effort can be found later in this chapter in *In the Spotlight: Advancing the Development and Use of Health Information Technology.*

Value-Based Purchasing

Value-based purchasing is the use of payment methods and other incentives to encourage substantive improvement for patient-focused, high-value care. At HHS, value-based purchasing is in its early stages of development. The Tax Relief and Health Care Act of 2006 (H.R. 6111) lays the groundwork for CMS to establish many models for financial and nonfinancial incentives used in value-based purchasing programs or strategies. Programs such as *Medicare Hospital Pay for Performance, Medicare Demonstration Project to Permit Gainsharing,* and the *Premier* demonstration are viewed as one component of a broader strategy of promoting health care quality. At least 12 States throughout the country have already implemented a wide range of value-based purchasing initiatives under Medicaid. States are using both payment differentials and nonfinancial incentives, such as auto-enrollment and public reporting, to reward performance. CMS will provide technical assistance to those States that voluntarily elect to implement value-based programs. CMS also will encourage States to include an evaluation component to provide evidence of the effectiveness of this methodology.

Quality Improvement Efforts

Medicare Quality Improvement Efforts. Improving quality of care and reducing medical errors are important goals in modernizing Medicare. The Medicare Web site will continue to display quality data that allow consumers to make informed choices by comparing the performance of hospitals, nursing homes, home health agencies, and dialysis facilities.

Medicaid Quality Improvement Efforts. States continue to advance efforts to improve overall quality of care as they seek new approaches to improve and expand insurance coverage. In many instances, State Medicaid programs have led the way in quality initiatives that have the potential to shape activities of other public and private payers across the country. Several States have implemented value-based purchasing programs with the objective of redesigning the payment structures to promote and reward the provision of high-quality care. At least 13 States now publicly report performance measurement data that can be used by State agencies, beneficiaries, policymakers, and others to promote transparency and personal responsibility in the care provided. CMS also has launched a *Neonatal Care Outcomes Improvement* project with an objective of decreasing infant morbidity and mortality.

Nursing Home Quality Initiatives. The *CMS Nursing Home Quality Initiative* is a broad-based effort that includes continuing regulatory and enforcement systems. New and improved consumer information is available through the 1–800–MEDICARE (1-800-633-42273) line and at the Medicare Web site. In addition, community-based nursing home quality improvement programs, and partnerships and collaborative efforts to promote awareness and support, are underway. The first goal of the initiative is to provide consumers with an additional source of information about the quality of nursing home care by establishing quality measures based on the Minimum Data Set and by publishing information on Medicare's Nursing Home Compare Web site. The second goal is to help providers improve the quality of care for their residents by giving them complementary clinical resources, quality improvement materials, and assistance from the Quality Improvement Organizations in every State.

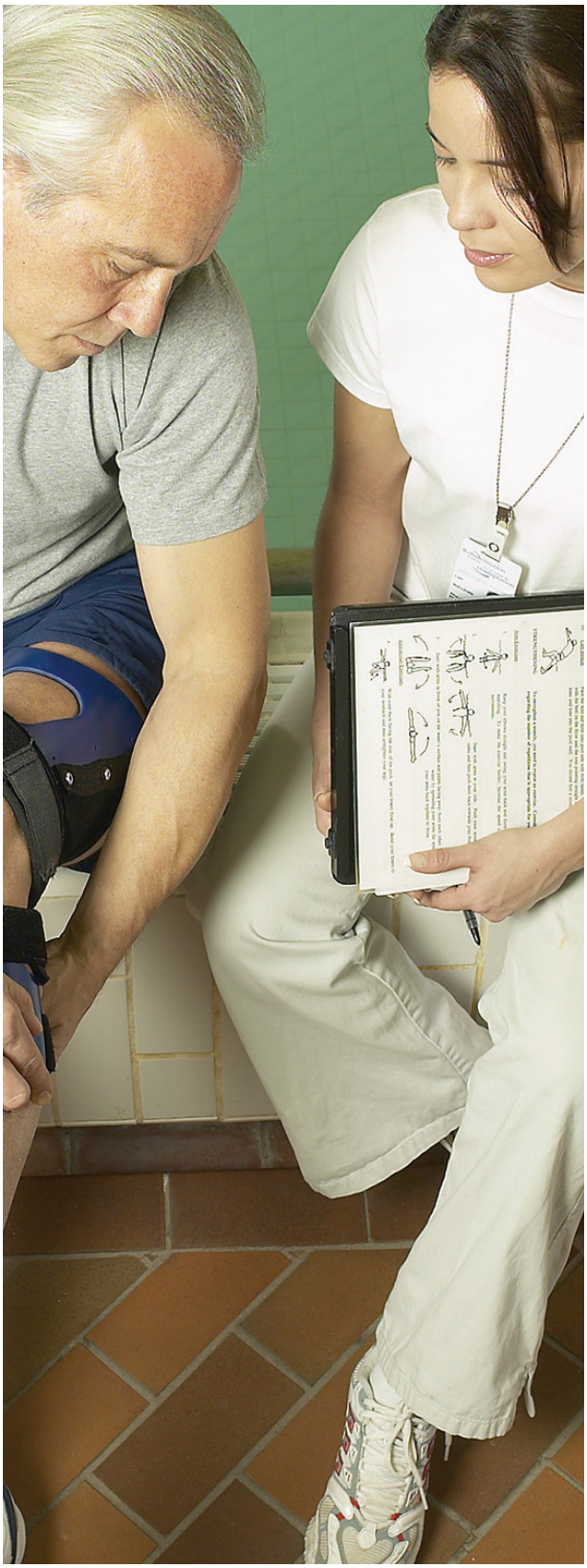
Collaborative Quality Improvement Initiatives. Two joint planning efforts focus on quality and improvement initiatives. With representation from CMS, CDC, AHRQ, and a number of non-Federal organizations, one effort experiments with approaches to create incentives for hospitals and physicians to provide both high-quality and efficient care (e.g., *Gainsharing, Hospital Compare, Surgical Care Improvement Project,* and others). The second effort, the *Quality Workgroup,* consists of CMS, AHRQ, IHS, ONC, the Office of Personnel Management, and a variety of non-Federal organizations representing labor, insurers, hospitals, and other stakeholders. The *Quality Workgroup* makes recommendations to the *American Health Information Community* (AHIC) so that health information technology can provide the data needed

for the development of quality measures that are useful to patients and others in the health care industry. The *Quality Workgroup* seeks to automate the measurement and reporting of a comprehensive current and future set of quality measures and to accelerate the use of clinical decision support that can improve performance on those quality measures. In addition, this workgroup makes recommendations on how performance indicators should align with the capabilities and limitations of health information technology. More information about the AHIC's work is included in the *Meeting External Challenges* section of this chapter.

Medical Home Quality Improvement Initiative. A medical home is primary care that is accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective. In a medical home, a pediatric clinician works in partnership with the patient and his or her family to assure that all the medical and nonmedical needs of the patient are met. Through this partnership, the pediatric clinician can help the patient and family access and coordinate specialty care, educational services, out-of-home care, family support, and other public and private community services that are important to the overall health of the child or youth and family. A HRSA initiative will identify effective strategies currently being used in collaboration with Title V Children with Special Needs programs in the States and will implement quality improvement activities within their medical home activities. The purpose is to enhance infrastructure development, provide quality care, and foster exchange of strategies among families, communities, and State and Federal leaders.

Medical Product Safety

FDA is responsible for addressing concerns regarding the safety of medical products, in particular, drugs. As the science of drug development continues to evolve, FDA will continually improve the approach to drug regulation to ensure that care providers and patients can make optimal decisions about the medicines they use to improve their health. FDA's reform effort will include developing new tools for communicating information to patients and improving the management of the process for



how FDA uncovers and communicates important drug safety issues. For example, FDA will focus on improving the safety of drugs on the market in part through its plans to modernize the Adverse Event Reporting System (AERS) and establish "AERS II" as the primary source for drug product adverse event data. These resources also will allow FDA to augment AERS data and further its efforts with CMS to obtain access to valuable drug safety information housed in CMS population-based databases. This collaboration with CMS will be integrated with the Sentinel System, a seamless platform for gathering and evaluating information about adverse events related to the use of medical products. This integration will enable FDA to gather more information from the point of care about potential safety problems and will provide a framework for turning these raw data into useful knowledge about the safe use of medical products.

In order to improve current processes and systems for collection of adverse events and errors, FDA is developing MedWatch Plus. This program will provide a single internet portal for anyone needing to report an adverse event resulting from an FDA regulated product, including product complaint reporting. This initiative will improve the collection and processing of adverse event information for all FDA regulated products. The user-friendly electronic submission capability will facilitate submission of adverse events reports to better allow FDA to efficiently and effectively use the information to promote and protect public health. Through these modernization efforts, FDA will continue to ensure that the medical products it regulates are the safest in the world.

OPHS coordinates vaccine safety activities among HHS agencies which conduct a broad range of activities aimed at ensuring the safety of vaccines. NIH conducts and funds basic research that leads to the development of vaccines with a major emphasis on safety. FDA has statutory responsibility for licensing vaccines. Additionally, the FDA coadministers the Vaccine Adverse Event Reporting System (VAERS), a passive surveillance system, with CDC. CDC also conducts active surveillance of vaccine associated adverse events through the Brighton Collaboration, and examines vaccine adverse events on the practice level through Clinical Immunization Safety Assessment (CISA) centers. HRSA compensates individuals who may have been injured by vaccines through the Vaccine Injury Compensation Program (VICP). The Federal government has a heightened responsibility to ensure that vaccines are optimally safe as vaccines are recommended for nearly ever child in the U.S. and children are required by state laws to receive vaccines in order to enter school. OPHS is coordinating an interagency strategic plan to enhance HHS vaccine safety activities. Vaccine safety activities will be enhanced in the areas of research and development, post-licensure surveillance, and risk communication.

Generic Drugs. Part of FDA's mission is to make sure that the generic drugs approved for use in the United States are just as safe and effective as the brand-name versions of the drugs. Generic drugs can be very helpful for patients because their price is typically much lower: For the average price of a brand-name prescription drug that is $72, the average price of a generic version is about $17.[xiii] This is an especially important source of drug savings at this time, because a growing number of important brand-name medications—more than 200 in the next few years—are coming off patent, paving the way for the development of generic versions. FDA's new final regulation to improve how and when generic drugs can compete with brand-name drugs will lead to saving billions of dollars in drug costs each year.

Health Disparities

The *Racial and Ethnic Health Disparities Outreach* joint planning effort focuses on outreach to raise awareness among minority communities about major health risks prevalent in their specific populations and to provide access to information on how to reduce these risks. AoA, CDC, IHS, NIH, OCR, and OPHS partner with media, State and local health departments, State and area agencies on aging, and tribal governments on this effort. Additional information on HHS's efforts on this topic can be found later in this chapter in *In the Spotlight: Reducing Health Disparities.*

Strategic Objective 1.4

Recruit, develop, and retain a competent health care workforce.

In the coming years, the Nation faces shortages of critical health care workers, including nurses and long-term care providers. In addition, all health care workers will need to be flexible and responsive enough to act on new challenges and maximize the potential of new technologies. In addition to strategies to develop its own workforce, HHS is committed to helping the field recruit and retain, as well as train, develop, and support, a competent professional and paraprofessional health care workforce. Among the operating and staff divisions contributing to the achievement of this objective are AoA, ASPE, CMS, HRSA, IHS, OPHS, and SAMHSA.

HHS, in the health care programs it operates, faces the same recruitment and retention challenges encountered by health care providers nationwide. The first performance indicator measures HHS's success in meeting its goal to recruit and retain the Commissioned Corps members needed to provide ongoing health care. The second measures the Corps' readiness to rapidly respond to medical emergencies and urgent public health needs.

Recruitment /Retention Efforts

Commissioned Corps. The mission of the Commissioned Corps of the United States Public Health Service (USPHS; Commissioned Corps) is protecting, promoting, and advancing the health and safety of the Nation. The Commissioned Corps achieves its mission through rapid and effective response to public health needs, leadership and excellence in public health practices, and the advancement of public health science. As one of the seven Uniformed Services of the United States, the Commissioned Corps is a specialized career system designed to attract, develop, and retain health professionals who may be assigned to Federal, State, or local agencies or international organizations. The Commissioned Corps will continue to offer two excellent opportunities for students through the highly competitive *Junior Commissioned Officer Student Training and Extern Program* and *Senior Commissioned Officer Student Training and Extern Program*.

Indian Health Service. The Indian Health Care Improvement Act of 1976 (Public Law 94-437), as amended, authorized IHS to administer interrelated scholarship programs to meet the health professional staffing needs of IHS and other health programs serving Indian people. In addition, IHS administers a *Loan Repayment Program* for the purpose of recruiting and retaining highly qualified health professionals to meet staffing needs. The *Indian Health Professions Program* provides scholarships, loans, and summer employment in return for agreements by students to serve in health facilities serving American Indians and Alaska Natives in medically underserved areas. As a matter of law and policy, IHS gives preference to qualified American Indians in applicant selection and in career development training.

National Health Service Corps. Currently, 35 million people live in communities without adequate access to primary health care because of financial, geographic, cultural, language, and other barriers. Since its inception, the National Health Service Corps (NHSC), managed by HRSA, has placed more than 27,000 primary care clinicians, including dental, mental, and behavioral health professionals, in underserved areas across the country including communities with Health Centers. In FY 2007, field strength for the NHSC is estimated to be more than 3,400 people.[xiv] Approximately half of NHSC clinicians are assigned to service in Health Center sites.

Nurses. The Bureau of Labor Statistics estimates that by 2020 the Nation will have a shortfall of up to 1 million nurses, which includes new jobs and "replacement" jobs that are open when today's nurses retire and leave the field.[xv] As the population continues to grow and age and medical services advance, the need for nurses will continue to increase. A report developed by HHS, *What is Behind HRSA's Projected Supply, Demand, and Shortage of Registered Nurses,* predicted that the nursing shortage is expected to grow to more than 1 million by 2020. In 2007, HHS nursing programs will support recruitment, education, and retention of nursing students, emphasizing new loan repayments and scholarships.

Workforce Support Efforts

Cultural Competence. OPHS's OMH is mandated to develop the capacity of health care professionals to address the cultural and linguistic barriers to health care delivery and increase access to health care for people with limited English proficiency. The *Center for Linguistic and Cultural Competence in Health Care* was established in FY 1995 as a vehicle to address the health needs of populations with limited English proficiency.

National Standards on Culturally and Linguistically Appropriate Services. These standards have been developed and are primarily directed at health care organizations; however, individual providers also are encouraged to use the standards to make their practices more culturally and linguistically accessible. The principles and activities of culturally and linguistically appropriate services should be integrated throughout an organization and undertaken in partnership with the communities being served. The standards are organized by three themes: Culturally Competent Care, Language Access Services, and Organizational Supports for Cultural Competence.

Mental Health and Substance Use Disorders Prevention and Treatment. SAMHSA supports efforts to identify and articulate key workforce development issues in the mental health and substance use disorders prevention and treatment fields and to encourage the retention and recruitment of an effective compassionate workforce. These efforts include support for programs that train behavioral health professionals to work with underserved minority populations, training for mental health and substance abuse providers, and leadership training programs.

Support to Family Caregivers. The *National Family Caregiver Support Program,* developed by AoA, calls for all States working in partnership with local area agencies on aging, faith- and community-service providers, and tribes to offer five direct services that best meet the range of family and informal caregivers' needs: information about available services; assistance in gaining access to supportive services; individual counseling, organization of support groups, and training to assist caregivers in making decisions and solving problems relating to their roles; respite care to enable caregivers to be temporarily relieved from their caregiving responsibilities; and supplemental services, on a limited basis, to complement the care provided.

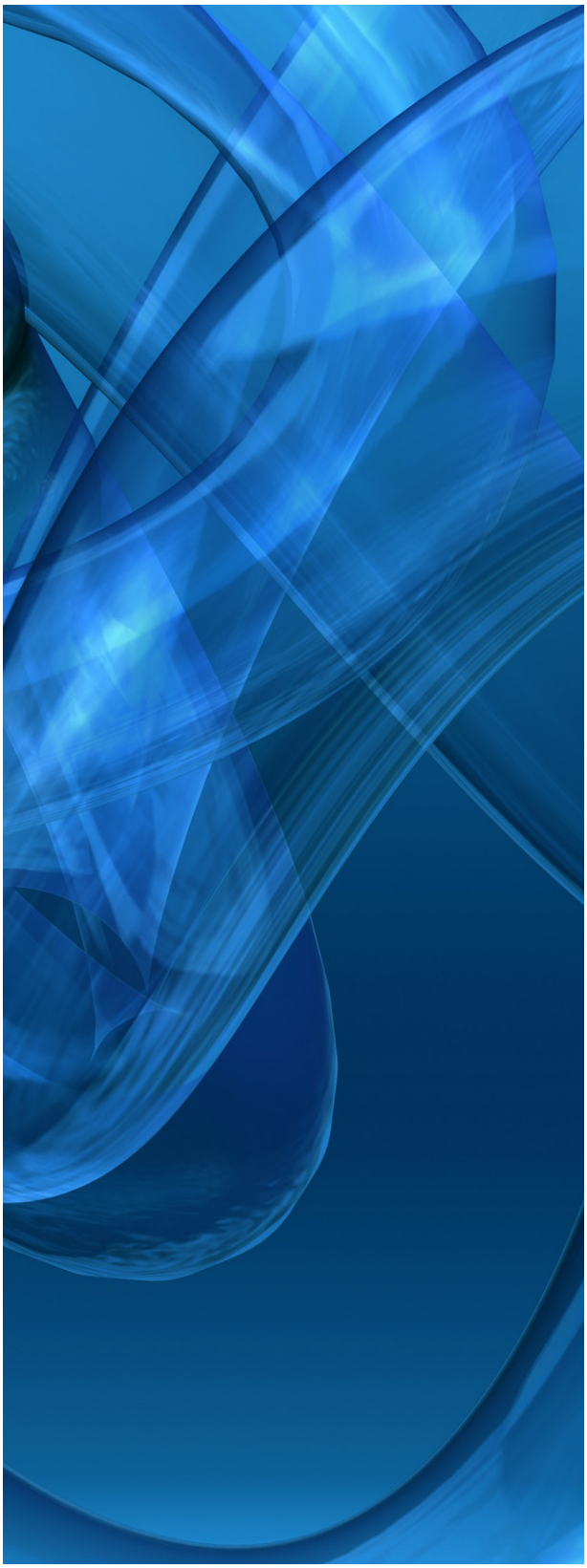
Direct Support Workforce. To address the emerging "care gap" between the number of long-term care workers and growing demand, providers, policymakers, and consumers are likely to consider a broad range of strategies: improving wages and benefits of direct care workers, tapping new worker pools, strengthening the skills that new workers bring at job entry, and providing more relevant and useful continuing education and training. A key strategy in this mix will be a focus on workforce development—providing workers with the knowledge and skills they need to perform their jobs. In addition, ASPE and its partners in and outside HHS are engaged in a series of research projects aimed at more accurately enumerating the long-term care workforce, describing the types of tasks performed and assessing the impact of workforce development programs.

Performance Indicators

		Most Recent Result	FY 2012 Target
Strategic Objective 1.1 **Broaden health insurance and long-term care coverage.**			
1.1.1	Implement the Medicare Prescription Drug Benefit – increase percentage of Medicare beneficiaries with Prescription Drug Coverage from Part D or other sources.	90%	93%
1.1.2	Reduce the percentage of improper payments made under the Medicare FFS Program.	4.4%	Available 2009
Strategic Objective 1.2 **Increase health care service availability and accessibility.**			
1.2.1	Increase the number of persons (all ages) with access to a source of ongoing care.	87%	96%
1.2.2	Expand access to health screenings for American Indians and Alaskan Natives: a) Increase the proportion of patients with diagnosed diabetes who receive an annual retinal examination; and b) Increase the proportion of eligible patients who have had appropriate colorectal cancer screening.	a) 49%; and b) 22%.	a) 75%; and b) 50%.
1.2.3	Increase the number of patients served by Health Centers.	14.1 million	16.4 million
1.2.4	Serve the proportion of racial/ethnic minorities in programs funded by Ryan White CARE Act at a rate that exceeds their representation in national AIDS prevalence data.	72%	5 percentage points above CDC data on national prevalence
1.2.5	Increase the number of client admissions to substance abuse treatment programs receiving public funding.	1,875,026	2,005,220

		Most Recent Result	FY 2012 Target
Strategic Objective 1.3 Improve health care quality, safety, cost, and value.			
1.3.1	Increase physician adoption of electronic health records.	10%	40%
1.3.2	Decrease the prevalence of restraints in nursing homes.	6.1%	5.8%
1.3.3	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.	0 States	12 States
Strategic Objective 1.4 Recruit, develop, and retain a competent health care workforce.			
1.4.1	Increase the number of Commissioned Corps response teams formed.	10 teams	36 teams
1.4.2	Increase the number of Commissioned Corps officers.	5,906	6,600

Note: Additional information about performance indicators is included in Appendix B.



Meeting External Challenges

HHS faces a number of challenges in improving the safety, quality, affordability, and accessibility of health care, including shifting demographics, changing trends in demand, increasing costs, and continuing concerns about implementing new technologies.

Demographic changes include the aging of the Nation's population and increasing life expectancy, a growing number of persons with disabilities, and an increasing number of populations who do not speak English and have low literacy. HHS is working to meet the challenge by targeting its outreach materials and media responses to these populations, monitoring trends in access and availability of care for these populations, and continuing to design and implement innovative demonstration programs and initiatives aimed at reducing disparities. For more information about this topic, see Chapter 4's *In the Spotlight: Demographic Changes and Their Impact on Health and Well-Being.*

With these demographic changes, changes in demand are expected to follow. Enhanced outreach to new populations means that HHS may need to think differently about responding to demands for high-quality, high-value, and accessible health care; behavioral health care; and long-term care. Surges in the Medicare-eligible population related to the aging of the Baby Boomers may strain the ability of the health care delivery system to respond appropriately. Even consumer perceptions about their need for preventive screenings or services impact overall demand. HHS is working to analyze background data from services provided to react to changing beneficiary needs. Evidence-based processes are being utilized to address coverage issues. Education campaigns are being conducted to raise awareness about beneficiary screening services and preventive care, with particular attention to growing racial and ethnic minority populations.

Although the above is true, one cannot assume that all costs are avoidable. Some of these costs substitute for the costs of excess mortality or morbidity. The United States continues to have the highest per capita health care spending among industrialized

countries. The health care cost per capita for persons aged 65 years or older in the United States is three to five times greater than the cost for persons younger than 65, and the rapid growth in the number of older persons, coupled with continued advances in medical technology, is expected to create upward pressure on health care and long-term care spending. Medical inflation also contributes to the rising cost of providing appropriate quality health services, widening the gap between increased need and available resources. An economic downturn could increase demand for health care and long-term care services from safety net providers and strain the ability of current providers to meet the demand. In response to these concerns, HHS will continue to monitor trends in access to care among uninsured, underinsured, and low-income individuals, and to design and implement innovative demonstration programs that seek to improve health and access to care among these groups. HHS will identify new resources to meet increased demands, focusing on efficiency and effectiveness of health care service delivery. HHS will also continue to cultivate a strong focus on prevention and wellness services (see *Strategic Goal 2, Objective 2.3,* for more detail).

Improving health care and the health of the population through the adoption of health information technology (health IT) is clearly a priority for HHS (see *In the Spotlight: Advancing the Development and Use of Health Information Technology*). The nationwide implementation of an interoperable health IT infrastructure has the potential to lower costs, reduce medical errors, improve the quality of care, and provide patients and physicians with new ways to interact. However, nationwide health IT adoption can be accomplished only through a coordinated effort of many stakeholders, from State and Federal governments and the private sector. HHS has taken great care to engage representatives from all of these sectors in all of our health IT initiatives—an effort that involves many processes and the work of many hundreds of participants. In September 2005, HHS formed a Federal Advisory Committee (subject to the Federal Advisory Committee Act[4] of 1972 (Public Law 92-463), as amended), the American Health Information Community (AHIC), to advise the Secretary on how to accelerate the development and adoption of health IT and help advance efforts needed to achieve the President's goal for most Americans to have access to secure electronic health records by 2014. Additionally, the AHIC provides input and recommendations to HHS on how to make health records digital and interoperable and how to protect the privacy and security of those records, in a smooth, market-led way.

4 In 1972, the Federal Advisory Committee Act (Public Law 92-463) was enacted by the U.S. Congress. Its purpose was to ensure that advice rendered to the executive branch by the various advisory committees, task forces, boards, and commissions formed over the years by the Congress and the President be both objective and accessible to the public. The act formalized a process for establishing, operating, overseeing, and terminating these advisory bodies.

The United States health care delivery system encompasses outstanding providers, facilities, and technology. Many Americans enjoy easy access to care. However, not all Americans have full access to high-quality health care.

The *National Healthcare Disparities Report (2006 Disparities Report),* published annually by the Agency for Healthcare Research and Quality (AHRQ), provides a comprehensive national overview of disparities in health care in America and tracks the Nation's progress toward the elimination of health care disparities.[xvi] Measures of health care access are unique to this report and encompass two dimensions of access: facilitators and barriers to care, and health care utilization.

Three key themes are highlighted for those who seek information to improve health care services for all Americans:

- Disparities remain prevalent;
- Some disparities are diminishing, while others are increasing; and
- Opportunities for reducing disparities remain.

HHS is undertaking numerous initiatives aimed at reducing health care disparities and improving overall health care quality. These include, for example:

- Activities coordinated by OCR, OPHS, and the HHS Disparities Council;
- AHRQ's "*Asthma Care Quality Improvement: A Resource Guide for State Action*";
- AHRQ's "*Diabetes Care Quality Improvement: A Resource Guide for State Action*," which provides background information on why States should consider diabetes as a priority for State action, presents analysis of State and national data and measures of diabetes quality and disparities, and gives guidance for developing a State quality improvement plan;
- AHRQ's "State snapshots" of data, which are made available to State officials and their public sector and private sector partners to understand health care disparities;
- AHRQ's national health plan learning collaborative to reduce disparities and improve diabetes care;
- CDC's *National Breast and Cervical Cancer Early Detection Program;*
- CMS's *Hospital, Nursing Home, Home Health, and End Stage Renal Disease Quality Initiatives;*
- HRSA's *C.W. Bill Young Cell Transplantation Program* and *National Cord Blood Inventory* to increase access to sources of high-quality blood stem cells for transplantation for patients without a suitable related blood stem cell donor;
- HRSA's *Health Disparities Collaborative Initiative,* which seeks to generate and document improved health outcomes for underserved populations;
- HRSA's *Healthy Start* program, which works in 97 communities with high annual rates of infant mortality to reduce disparities and improve health outcomes for mothers and infants from pregnancy to at least 2 years after delivery;
- HRSA's *Maternal and Child Health Block Grant,* aimed at improving care for all mothers and children; and
- HRSA's *Organ Donation Collaborative,* aimed at increasing the number of organ donations and transplants.

Disparities Persist

Findings in the *2006 Disparities Report* are consistent with those of previous reports: Disparities related to race, ethnicity, and socioeconomic status still pervade the health care system, and are observed in almost all aspects of health care, including:

- Across all dimensions of *quality of care,* including effectiveness, patient safety, timeliness, and patient centeredness;
- Across all dimensions of *access to care,* including facilitators and barriers to care and health care utilization;
- Across many *levels and types of care,* including preventive care, treatment of acute conditions, and management of chronic disease;
- Across many *clinical conditions,* including cancer, diabetes, end stage renal disease, heart disease, HIV disease, mental health, substance abuse, and respiratory diseases;
- Across many *care settings,* including primary care, home health care, hospice care, emergency de-

partments, hospitals, and nursing homes; and
- Within many *subpopulations,* including women, children, older adults, residents of rural areas, and individuals with disabilities and other special health care needs.

Changes in Disparities

For racial and ethnic minorities, some disparities in quality of care are improving and some are worsening. Of disparities in quality experienced by Blacks or African-Americans, Asians, American Indians and Alaska Natives, and Hispanics,[5] about a quarter were improving and about a third were worsening; two-thirds of disparities in quality experienced by poor people were worsening.

Some examples of changes in differences related to the quality of health care follow:

- From 2000–2003, the proportion of adults who received care for illness or injury as soon as wanted decreased for Whites but increased for Blacks or African-Americans. From 2000–2004, the rate of new AIDS cases remained about the same for Whites but decreased for Blacks or African-Americans.
- From 1999–2004, the proportion of adults age 65 and over who did not receive a pneumonia vaccine decreased for Whites but increased for Asians. From 1998–2004, the proportion of children ages 19 to 35 months who did not receive all recommended vaccines decreased somewhat for Whites but even more for Asians.
- From 2000–2003, the proportion of adults who had not received a recommended screening for colorectal cancer decreased for Whites but increased for American Indians and Alaska Natives. From 2002–2003, the proportion of adults who reported communication problems with providers decreased somewhat for Whites but even more for American Indians and Alaska Natives.
- From 2001–2003, the rate of pediatric asthma hospitalizations remained the same for non-Hispanic Whites but increased for Hispanics. From 2001–2003, the proportion of children without a vision check decreased somewhat for non-Hispanic Whites but even more for Hispanics.
- From 2000–2003, the proportion of adults age 40 and older who did not receive three recommended services for diabetes decreased substantially for high-income persons but less for poor persons. From 2001–2003, the proportion of children whose parents reported communication problems with providers remained about the same for high-income persons but decreased for poor persons.

Opportunities for Improvement

Although some inequalities are diminishing, there are many opportunities for improvement. For all groups, measures could be identified for which the group not only received worse care than the reference group but for which this difference was getting worse rather than better.

All groups had several measures for which they received worse care and for which the difference was getting worse. For Blacks or African-Americans, Asians, and Hispanics, imbalances in health care delivery involved all the following domains of quality that could be tracked: preventive services, treatment of acute illness, management of chronic disease and disability, timeliness, and patient-centeredness. For American Indians and Alaska Natives, these negative factors appeared concentrated in the treatment of acute illness and the management of chronic disease and disability.

Hispanics and the poor faced many inequalities in access to care that were getting worse:

- For Hispanics, not having health insurance and a usual source of care worsened; and
- For the poor, not having a usual source of care and experiencing delays in care worsened.

Some disparities in quality of care were prominent for multiple groups, such as colorectal cancer screening, vaccinations, hospital treatment of heart attack, hospital treatment of pneumonia, services for diabetes, children hospitalized for asthma, treatment of tuberculosis, nursing home care, problems with timeliness, and problems with patient-provider communication.

5 In this section, the terms used for specific racial and ethnic minorities are consistent with the categories used in the *2006 Disparities Report.* The *2006 Disparities Report* officially uses the term "Blacks or African Americans" in accordance with the Office of Management and Budget (OMB). "Asian" includes "Asian or Pacific Islander" when information is not collected separately for each group. For all measures, Blacks, Asians, and American Indians and Alaska Natives are compared with Whites; Hispanics are compared with non-Hispanic Whites; and poor individuals are compared with high-income individuals.

Health information technology is defined as systems and products that electronically create, store, transmit, and present personal health information for multiple purposes, most notably for patient care.

The Institute of Medicine estimates that 44,000 to 98,000 Americans die each year from medical errors. Many more die or have permanent disability because of inappropriate treatments, mistreatments, or missed treatments in ambulatory settings. Predictive models have projected that as much as $300 billion is spent each year on health care that is the result of our fragmented, uninformed, and uncoordinated health care system. According to the National Coalition on Health Care, in 2004 health care spending in the United States reached $1.9 trillion and was projected to reach $2.9 trillion in 2009, if the current system does not change. In order for health care in the United States to be safe, timely, effective, efficient, equitable, and patient centered, three elements will be necessary:

- All relevant information (about a patient, the latest scientific evidence, and environmental factors) must be available electronically at the time of patient care;
- Patients must be informed and engaged in their own health; and
- Care must be considered, assessed, and coordinated across multiple sites and settings.

Clearly, health IT is the critical tool that can significantly reduce medical error, engage consumers and patients in their own health and care, and provide information in a coordinated fashion. In addition, public health and bioterrorism surveillance can be seamlessly integrated into care, and clinical research will be accelerated and postmarketing surveillance expanded. Interoperable health IT is the key to transforming our health care system.

Office of the National Coordinator

The Office of the National Coordinator for Health Information Technology (ONC) provides leadership for the development and nationwide implementation of interoperable health information technology, which has the potential to lower costs, reduce medical errors, improve the quality of care, and provide patients and physicians with new ways to interact. The National Coordinator is the Secretary's principal advisor on the development, application, and use of health IT; coordinates HHS's health IT programs; ensures that HHS health IT policy and programs are coordinated with those of other relevant executive branch agencies; and coordinates public/private partnerships focused on the health IT agenda.

ONC's principal goal is the achievement of interoperable electronic health records available to most Americans by 2014. Achieving this goal requires activities across a broad range of areas including standards development, certification processes, piloting of health information exchanges across a number of clinical domains and markets, and solid survey techniques to track progress in adoption. In addition to addressing the technical issues, the Office is focused on privacy and security concerns; medicolegal issues; incentives, financial alignments, and business cases; and workforce/cultural needs. These activities will be undertaken through coordinating large, collaborative partnerships between public and private organizations to receive the breadth of input necessary to change the course and outcome of our Nation's health care system. A number of operating and staff divisions within HHS have a successful history of designing and delivering successful health IT

solutions; these include AHRQ, CMS, and HRSA. ONC's coordinating role will serve to support these existing strengths and help identify synergies that can be achievable through leveraging these organizations and others toward a unified health IT strategy not only for HHS, but also for the Nation as a whole.

Public/Private Partnerships

On September 13, 2005, Secretary Leavitt announced the membership for the *American Health Information Community*. The original purpose of the Community was to help advance efforts to reach President Bush's call for most Americans to have electronic health records within 10 years. The Community, a federally chartered advisory committee, provides input and recommendations to HHS on how to make health records digital and interoperable and how to assure the privacy and security of those records, in a smooth, market-led way.

The Community has 18 members including the Secretary of HHS serving as the Chair. The remaining 17 members are a combination of key leaders in the public and private sectors who represent stakeholder interests in advancing the mission of the Community and who have strong peer support. The Community is chartered for 2 years, with the option to renew for no more than 5 years. The Department intends for the Community to be succeeded within 5 years by a private-sector health information community initiative that, among other activities, would set additional needed standards, certify new health IT, and provide long-term governance for health care transformation.

Standards Harmonization

Many electronic health records have strong functionality, but no portability. The patient's health information cannot be transferred to other electronic systems, thus precluding availability of that information in multiple care settings.

The standards harmonization process carried out by the *Health Information Technology Standards Panel* (HITSP) has created a unique and unprecedented opportunity to bring together the intellectual assets of more than 200 organizations with a stake in health data standards that will increase the portability and security of data among electronic health records. The panel guides the collaboration of these organizations through a health IT standards harmonization process that leverages the work and membership of multiple standards development organizations. The panel engages in a consensus-based process to select the most appropriate standard from existing standards where available and to identify gaps in standards where there are none to assure effective interoperability. Once standards have been identified to support specific clinical use cases, the HITSP develops implementation guides to support system developers' activities in pursuing interoperable electronic health records.

Certification Process

Health IT is considered a normal cost of doing business to ensure patients receive high-quality care while protecting patients' privacy and personal information. In the same way, the certification process ensures that certain criteria are met with regard to functionality, interoperability, and security, thus assuring the purchaser that the product will meet these needs.

The *Certification Commission for Health Care Information Technology* (CCHIT) has created an efficient, credible, and sustainable product certification program. The CCHIT membership includes private sector representatives from physicians and other health care providers, payers and purchasers, health IT vendors, and consumer groups—all focused on accelerating the adoption of interoperable health IT. In addition to developing criteria and evaluation processes for certifying ambulatory and inpatient electronic health records, the CCHIT will certify infrastructure or network components through which electronic health records interoperate.

Health Information Exchange

Much like the Automated Teller Machine networks or cellular telephone networks, the ability to move needed patient information regionally and nationwide in support of their care should be transparent to patients and their providers. Linking previously disparate health care

information systems involves more than communication standards because the movement of information from one location to another implies moving from one authorized provider to another authorized provider in a secure fashion while ensuring that the correct patients' data are linked. Patient identity, authorization, authentication, and other standards are necessary to ensure that patients' needed health information is available at the right time and place.

Policy Council

The mission of the *Interagency Health Information Technology Policy Council* is to coordinate Federal health IT policy decisions across Federal departments and entities that will drive Federal action necessary to realize the President's goals of widespread health IT adoption. The Policy Council will address health IT policy issues raised by its members, the American Health Information Community, the National Committee on Vital and Health Statistics, and others. The initial focus of the Policy Council is to establish a strategic direction for Federal policy and identify accelerators to support breakthroughs of the Community. To accelerate health IT initiatives, the Policy Council will consider Federal policy levers such as procurement, reimbursement, new or modified regulation, program guidance, incentives for private sector activity, and research.

Federal Health Architecture

Under the leadership of ONC, *Federal Health Architecture* (FHA) will provide the structure "architecture" for collaboration and interoperability among Federal health efforts. FHA is one of five Lines of Business supporting the President's Management Agenda goal to expand electronic government. FHA will create a consistent Federal framework to facilitate communication and collaboration among all health care entities to improve citizen access to health-related information and high-quality services. It will link health business processes to their enabling technology solutions and standards to demonstrate how these solutions achieve improved health performance outcomes. It also will provide the ability to identify cross-functional processes, redundant systems, areas for collaboration, and opportunities to enhance interoperability in critical information systems and infrastructure.

Public Health Information Network

Supporting the national health IT agenda and FHA is the *Public Health Information Network* (PHIN), a national initiative to implement a multiorganizational business and technical architecture for public health information systems. With the acceptance of IT as a core element of public health, public health professionals are actively seeking essential tools capable of addressing and meeting the needs of the community.

PHIN will elevate and integrate the capabilities of public health information systems across the wide variety of organizations that participate in public health and across the wide variety of interrelated public health functional needs. PHIN targets the support and integration of systems for disease surveillance, national health status indicators, data analysis, public health decision support, information resources and knowledge management, alerting and communications, and the management of public health response.

PHIN includes a portfolio of software solutions and artifacts necessary in building and maintaining interconnected information systems throughout public health at the local, State, and Federal levels. PHIN advances the Nationwide Health Information Network and the national health IT agenda by embracing the standards identified by the Health Information Technology Standards Panel.

Privacy and Security Solutions

The *Privacy and Security Solutions for Interoperable Health Information Exchange* contract is comanaged by AHRQ and ONC. This contract has fostered an environment in which States and territories have been able to assess variations in organization-level business policies and State laws that affect health information exchange, identify and propose practical solutions while preserving the privacy and security requirements in applicable Federal and State laws, and develop detailed plans to implement solutions

to identified privacy and security challenges. These implementation plans will not only benefit the States and territories that have created them, but other ONC-coordinated efforts, such as the *State Alliance for E-Health's Health Information Protection Taskforce,* in which interstate health information exchange issues can be harmonized nationwide.

In addition, the American Health Information Community has formed the *Confidentiality, Privacy and Security Workgroup,* and the Office for Civil Rights (OCR) participates in the workgroup to ensure that privacy protections are embedded in the health IT infrastructure.

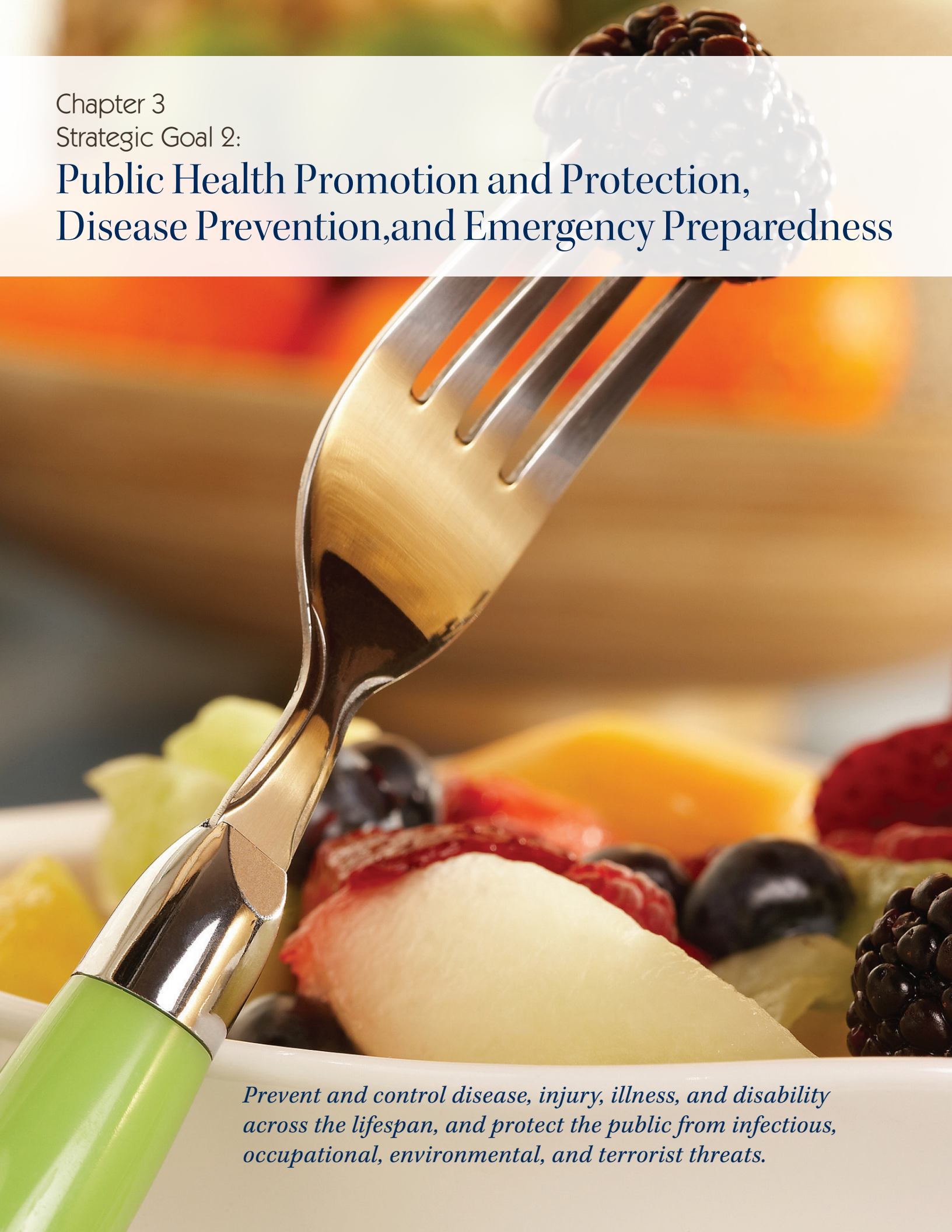
The State Alliance for eHealth (State Alliance), a contract awarded by ONC to the National Governors Association Center for Best Practices, is an initiative designed to improve the Nation's health care system through the formation of a collaborative body of governors and high level state executives. The State Alliance is charged to develop consensus solutions to barriers to health information exchange and adoption of health IT while preserving privacy, security, and consumer protections. It also builds consensus in seeking the harmonization of the variations in State policies, regulations, and laws.

The Challenge

Providing interoperable health records for most Americans by 2014 will require the dedicated perseverance of most divisions within HHS and many departments outside HHS. The great number of broad, collaborative public/private groups mentioned above is essential to identify our direction and realize our vision. Assembling the major groups has largely been accomplished, and a number of goals and objectives have been defined. The task before us now is to synergize our efforts through these collaborative processes and to move methodically forward in achieving these goals.

Chapter 3
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.

Throughout the 20th century, advances in public health and medicine resulted in reduced morbidity and mortality from infectious diseases, including influenza, polio, and foodborne and waterborne illnesses. 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. In the new millennium, the Nation continues to face the challenge of chronic disease because of unhealthy and risky behaviors, environmental exposures, and an aging population.

STRATEGIC GOAL 2: PUBLIC HEALTH PROMOTION AND PROTECTION, DISEASE PREVENTION, AND EMERGENCY PREPAREDNESS

Strategic Objective 2.1:
Prevent the spread of infectious diseases.

Strategic Objective 2.2:
Protect the public against injuries and environmental threats.

Strategic Objective 2.3:
Promote and encourage preventive health care, including mental health, lifelong healthy behaviors, and recovery.

Strategic Objective 2.4:
Prepare for and respond to natural and manmade disasters.

Today, chronic diseases continue to be significant health problems that face Americans. As HHS works to address these health issues, infectious diseases have reemerged as a priority for public health in the United States. For example, risky behaviors such as unprotected sex and injecting drug use continue to result in new HIV/AIDS infections. At the end of 2003, an estimated 1,039,000 to 1,185,000 persons in the United States were living with HIV/AIDS.[xvii] According to the Centers for Disease Control and Prevention (CDC), approximately 40,000 persons are infected with HIV each year. Injecting drug use is also a common current risk factor for hepatitis C virus (HCV) infection. About 30,000 Americans are infected with HCV each year, and about 3 million are chronically infected with this virus, which is a leading indication for liver transplants and hastens the progression of HIV in those who are coinfected.

Foodborne diseases cause an estimated 76 million illnesses, 325,000 hospitalizations, and 5,000 deaths in the United States each year. Other known pathogens account for an estimated 14 million illnesses, 60,000 hospitalizations, and 1,800 deaths annually.[xviii] Morbidity and mortality from injuries and environmental hazard exposures also continue to affect the health and well-being of Americans.

Over the past century, public health advances in drinking water, wastewater, and recreational water quality have dramatically improved the health of the American people. However, drinking water from public water systems causes an estimated 4 to 16 million cases of gastrointestinal illness per year. During 2003–2004, 62 waterborne disease outbreaks associated with recreational water were reported by 26 States and Guam. Illness occurred in 2,698 persons, resulting in 58 hospitalizations and 1 death.[xix]

Although malaria is technically preventable and curable if recognized and treated promptly, it remains one of the world's greatest threats to human health and economic welfare. Each year, malaria kills more than 1 million people—the majority, young children in Africa. In a retrospective analysis, it has been estimated that economic growth per year of countries with intensive malaria was 1.3 percent lower than that of countries without malaria.[xx]

The 21st century is also marked by the threat of public health emergencies. These threats have become a significant focus for public health at the Federal, State, and local levels. Public health threats and emergencies can ensue from myriad causes—bioterrorism; natural epidemics of infectious disease; terrorist acts that involve conventional explosives, toxic chemicals, or radiological or nuclear devices; industrial or transportation accidents; and climatological catastrophes.

Strategic Goal 2, *Public Health Promotion and Protection, Disease Prevention, and Emergency Preparedness,* seeks to address these problems. There are four broad objectives under *Public Health:*

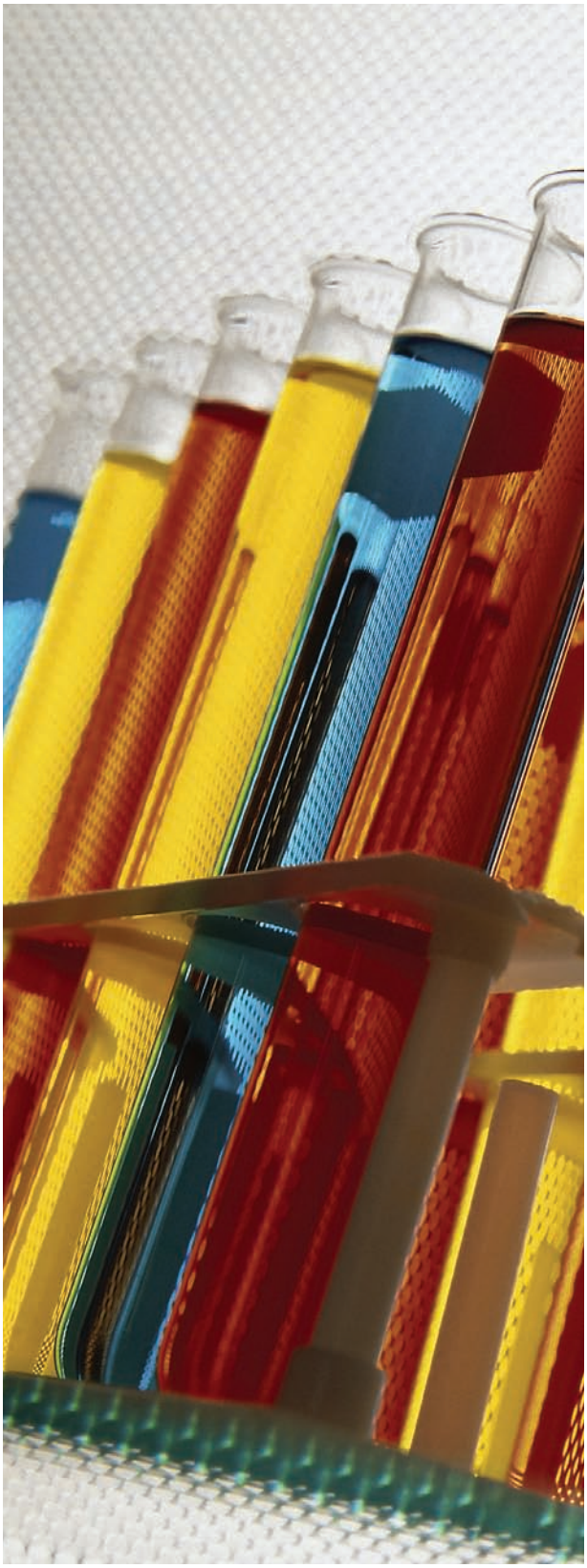
- Prevent the spread of infectious diseases;
- Protect the public against injuries and environmental threats;
- Promote and encourage preventive health care, including mental health, lifelong health behaviors, and recovery; and
- Prepare for and respond to natural and manmade disasters.

HHS is positioned to address the public health problems of infectious diseases, injuries and environmental hazards, chronic diseases and behavioral health problems, and public health emergencies through a comprehensive set of strategies. HHS provides leadership on these health issues within the Federal Government and collaborates with numerous partners across the Federal Government to achieve these objectives. These partners include the U.S. Departments of Homeland Security and Defense for public health emergency preparedness; the U.S. Environmental Protection Agency (EPA) and U.S. Department of Labor for environmental and occupational health issues; and the U.S. Departments of Agriculture and Commerce, and EPA, for food safety.

Within HHS, multiple operating and staff divisions work together to develop and implement strategies to achieve the goal of preventing and controlling disease, injury, illness, and disability across the lifespan and of protecting the public from infectious, occupational, environmental, and terrorist threats. Key operating and staff divisions that contribute to this goal include the Centers for Disease Control and Prevention

(CDC), Food and Drug Administration (FDA), Health Resources and Services Administration (HRSA), Office of the National Coordinator for Health Information Technology (ONC), Office of the Assistant Secretary for Preparedness and Response (ASPR), and Substance Abuse and Mental Health Services Administration (SAMHSA). In addition, HHS's Administration on Aging (AoA), Centers for Medicare & Medicaid Services (CMS), Office for Civil Rights (OCR), Office on Disability (OD), Office of Global Health Affairs (OGHA), and Office of Public Health and Science (OPHS) play important roles in addressing this goal.

Below is a description of each strategic objective, followed by a description of the key programs, services, and initiatives the Department is undertaking to accomplish those objectives. Key partners and collaborative efforts are included under each relevant objective. The performance indicators selected for this strategic goal are also presented with baselines and targets. These measures are organized by objective. Finally, this chapter discusses the major external factors that will influence HHS's ability to achieve these objectives, and how the Department is working to mitigate those factors.



Strategic Objective 2.1

Prevent the spread of infectious diseases.

Although modern advances have conquered some diseases, infectious diseases continue to threaten the Nation's health. Outbreaks of Severe Acute Respiratory Syndrome (SARS), avian influenza, West Nile Virus, and monkeypox are recent reminders of the extraordinary ability of microbes to adapt and evolve to infect humans. Earlier predictions of the elimination of infectious diseases often did not take into account changes in demographics, migration patterns, and human behaviors, as well as the ability of microbes to adapt, evolve, and develop resistance to drugs. Infectious disease can have significant medical and economic consequences. Addressing foodborne illnesses, vectorborne pathogens, viral hepatitis, HIV/AIDS and other sexually transmitted infections, tuberculosis, antimicrobial resistance, and a possible influenza pandemic is a significant priority for HHS. Although these diseases affect all Americans, many often hit hardest the most vulnerable populations—the low-income population, minorities, children and youth, immigrants, persons who are incarcerated, and other disenfranchised populations. The selected performance indicators at the end of this chapter were chosen to reflect the impact HHS has on these populations.

Immunization

HHS has identified several key strategies for addressing the threat of infectious diseases. One of the primary strategies is the use of vaccines. HHS's vaccine enterprise includes outreach activities and funding support for childhood and adult immunization. HHS, through CDC, will protect Americans from vaccine-preventable diseases by providing health communication messages about vaccination and supporting efforts to increase immunization coverage rates for both children and at-risk adults. OPHS coordinates and ensures collaboration among the many Federal agencies involved in vaccine and immunization activities. The Assistant Secretary for Health (ASH) provides leadership and coordination among Federal agencies, as they work together to carry out the goals of the *National Vaccine Plan*. The *National*

Vaccine Plan provides a framework, including goals, objectives, and strategies, for pursuing the prevention of infectious diseases through immunizations. In 2007–2008, HHS will review and revise the existing *National Vaccine Plan* to ensure that it addresses new scientific and safety issues that have emerged since the first plan was developed. HHS also will continue existing efforts to increase immunization rates for vaccine-preventable illness. Specifically, HHS, through CDC, will develop and disseminate health communication messages about vaccination and support efforts to increase immunization coverage rates for both children and adults.

The *Vaccines for Children Program* (VFC), which provides immunizations for eligible children[6] at their doctors' offices, will continue to be a cornerstone of the HHS infectious disease prevention strategy. VFC also helps children whose insurance does not cover vaccinations when they receive them at participating Federally Qualified Health Centers and Rural Health Clinics. HHS also will work to increase rates of vaccination against influenza and pneumococcal viruses through its National Influenza and Pneumococcal Vaccination Campaign. This joint initiative involves CDC, CMS, FDA, HRSA, IHS, and NIH along with State and local health departments, Medicaid agencies, tribal representatives, health care providers, and the National Coalition for Adult Immunization. It aims to provide vaccinations for influenza and pneumonia to beneficiary populations.

HIV/AIDS

OPHS coordinates all HIV/AIDS-related scientific and policy matters, such as new developments and program activities within the areas of research, HIV prevention, HIV care and treatment, and budget development. OPHS also ensures the effective and accountable management of the Department's HIV/AIDS programs.

Building on its existing surveillance, research, and screening activities, CDC applies well-integrated, multidisciplinary programs of research, surveillance, risk factor, and disease intervention to prevent and control the spread of HIV infection. For example, CDC is the source of national data on the epidemic and supports prevention programs in every State, guided by community planning. These programs reach those at highest risk for acquiring or transmitting infection with effective interventions to reduce their risk and protect their health. CDC and HRSA will support efforts to increase knowledge of community capacity to respond to HIV and increase HIV testing status, focusing especially on groups and communities at the highest risk of infection. FDA is responsible for ensuring the safety of the Nation's blood supply by minimizing the risks of infectious disease transmission and other hazards while facilitating an adequate supply of blood and blood products.

Routine and targeted HIV testing will be key strategies for preventing new HIV infections and improving outcomes for those who test positive. Individuals infected with HIV who are aware of their infection are less likely to engage in risky behaviors and are more likely to take steps to protect their partners. Additionally, individuals infected with HIV who are aware of their infection can take advantage of the therapies that can keep them healthy and extend their lives.

Additionally, FDA will continue its work with international drug regulatory authorities to promote expedited review of generic antiretroviral drugs under the *President's Emergency Plan for AIDS Relief* (PEPFAR). HHS, through its operating divisions, especially CDC and HRSA, is one of the major implementing partners for PEPFAR, and manages prevention, treatment, and care activities in the 15 focus countries of the Emergency Plan and more than 20 others. HHS also provides part of the Federal Government's financial contribution to the Global Fund to fight AIDS, tuberculosis, and malaria, and is part of the interagency team that guides U.S. policy toward the fund.

6 Children 18 years of age and younger who meet at least one of the following criteria are eligible: (1) a child who is eligible for the Medicaid program; (2) a child who has no health insurance coverage; (3) American Indian or Alaska Native; (4) a child, if served by a Federally Qualified Health Center or Rural Health Clinic, whose health insurance benefit plan does not include vaccinations.

Zoonotic[7]/Vectorborne Diseases

To address zoonotic and vectorborne diseases, HHS will develop plans to respond to a disease outbreak that encompasses animal, vector, and human experts working in synergy. CDC will develop disease surveillance systems that incorporate animal, vector, and human data to provide an effective public health response that will mitigate the impact of a multispecies outbreak. CDC will develop, test, and deploy improved methods for the detection and control of insectborne viruses and bacteria and will improve the capacity to detect the intentional release of plague, Rabbit Fever (tularemia), and other agents with bioterror potential. FDA will foster the development of preventive vaccines for malaria, dengue fever, and other vector-borne and zoonotic diseases by working with industry and academia. In addition, surveillance, detection, and response systems will be developed and tested to address domestic and international epidemics of vectorborne pathogens with the potential to harm the U.S. population.

Foodborne/Waterborne Illnesses

To combat foodborne illness, FDA and CDC will work together to protect public health through preventive strategies that improve surveillance, inspection, tracking, detection, investigation, control, and prevention of foodborne outbreaks and disease; strengthen the enforcement of regulations; and broaden education about these problems. HHS will improve the important national collaborative surveillance and response networks of the FoodNet, PulseNet, and OutbreakNet to make them faster, more responsive, and capable of more detailed investigations. FDA and CDC, along with the U.S. Department of Agriculture, and other organizations, will continue to participate in the Council to Improve Foodborne Outbreak Response, a group created to develop tools that facilitate the investigation and control of foodborne disease outbreaks. Over the next several years, the Council will develop multistate outbreak guidelines, a repository for resources and tools, and performance indicators for the response to enteric disease.

To address waterborne diseases, CDC will continue to partner with EPA to fill critical data gaps by providing improved disease surveillance data, creating evidence-based guidelines and training for investigations, expanding access to water-related information, collecting data to define the magnitude and burden of waterborne illness, evaluating water-related interventions to improve public health, and developing laboratory sampling and detection methodologies. As part of its preparedness effort, CDC will also develop, improve, and deploy rapid sampling and detection methods for potential waterborne threats. Providing comprehensive public health protection to all community users of water will create a more effective Federal response aimed at reducing the burden of waterborne disease in the United States.

Global Health

One key strategy for preventing the spread of infectious disease is preventing it from reaching the United States. HHS will collaborate with the World Health Organization (WHO) and other international partners to provide epidemiologic and laboratory support to assist countries in addressing disease threats through improved disease detection. HHS also will provide programmatic expertise, training, and funding support to assist with surveillance, control, elimination, and eradication activities for diseases such as measles, polio, avian influenza, and HIV/AIDS, as well as the provision of technical assistance with safe and healthy water and improved sanitation.

Immunization has revolutionized child health in countries throughout the world. WHO estimates that almost 40 percent of child deaths for children younger than 5 years of age are potentially preventable by vaccines.[xxi] HHS has been a major supporter of global initiatives to eradicate polio; control measles; and introduce new vaccines for pneumoccocal diseases, rotavirus, and possibly in the near future, malaria and even HIV. HHS remains committed to achieving

7 Zoonotic diseases are caused by infectious agents (such as mosquitoes) that can be transmitted between (or are shared by) animals and humans.

global polio eradication and meeting the global target to achieve a 90 percent reduction in measles mortality by 2010 as compared to 2000. Efforts to combat vaccine- preventable diseases overseas not only assist global efforts at lowering child mortality, but also help to protect U.S. children from susceptibility to these debilitating diseases.

One specific set of activities that HHS will continue in support of its global health strategy is in the area of malaria prevention. CDC supports prevention and control of malaria throughout the world in partnership with local, State, and Federal agencies in the United States; medical and public health professionals; national and international organizations; and foreign governments. Specific strategies include conducting malaria surveillance, prevention, and control activities in the United States; providing consultation, technical assistance, and training to malaria-endemic countries to change and implement proven policies to decrease malaria burden; conducting multidisciplinary research in the laboratory and in the field, to develop new tools and improve existing interventions against malaria worldwide; and translating research findings into appropriate global policies and effective practices through the *Roll Back Malaria Partnership* and other international partners.

HHS will continue to work with other Federal partners to control malaria through participation in the *President's Malaria Initiative* (PMI), an intergovernmental initiative led by the United States Agency for International Development (USAID), CDC, NIH, the U.S. Departments of State and Defense, and the National Security Council. The goal of PMI is to reduce malaria deaths by half in each target country after 3 years of full implementation. The initiative helps national governments deliver proven, effective interventions—insecticide-treated bed nets, indoor residual spraying, prompt and effective treatment with artemisinin-based combination therapies, and intermittent preventive treatment to people at greatest risk, pregnant women and children younger than 5 years old. As of June 2007, work is ongoing in the first three PMI countries (Angola, Tanzania, and Uganda) as well as the four added in 2006 (Malawi, Mozambique, Rwanda, and Senegal). Later in 2007, activities will begin in the final eight countries (Benin, Ethiopia, Ghana, Kenya, Liberia, Madagascar, Mali, and Zambia), which will bring the program to its full complement of 15 countries with a high burden of malaria in Africa.

Additional information about HHS's efforts in global health can be found later in this chapter in *In the Spotlight: Global Health Initiatives.*

Strategic Objective 2.2

Protect the public against injuries and environmental threats.

Injuries are the leading cause of death among children and adults younger than 44 years of age in the United States. About 160,000 people die each year in the United States from injuries; millions more are injured and survive[xxii]; and nearly 30 million people sustained injuries serious enough to require treatment in an emergency room. Many injured people are left with long-term disabilities.

HHS has a particular responsibility to provide the science base needed to reduce occupational injuries; the performance indicators at the end of this chapter measure this progress. CDC conducts the majority of injury prevention activities that support this objective. CDC focuses on strategies to address interpersonal violence, residential fires, falls, and workplace injuries and mortality. These include identifying risk factors, conducting surveillance, and supporting implementation activities.

Workplace Injuries

CDC promotes safe and healthy workplaces through interventions, recommendations, and capacity building. To achieve the objective of protection against injuries in the workforce population, CDC actively engages employers to promote commercial motor vehicle safety by providing technical assistance and disseminating Hazard Alerts and Fact Sheets that present practical prevention strategies in both English and Spanish. CDC also works with the Mine Safety and Health Administration on the joint committee examining how the newly developed personal dust monitor (PDM) can be utilized on a daily basis in underground coal mines. The PDM, recently developed by CDC in collaboration with manufacturers, labor, and industry, assesses coal miners' exposure to coal dust in underground mines and represents the first advancement in more than 30 years for monitoring exposures.

Fire-Related Injury Prevention

CDC will continue to support State programs to monitor, identify, and track fire-related injuries and to expand smoke alarm installation and fire safety education programs in communities at high risk.

Environmental Hazards

Interactions between people and their environment also pose a risk to their health. Environmental health hazards include water pollutants, chemical pollutants, air pollutants, mold, and radiation from natural, technologic, or terrorist events. HHS works in collaboration with other Departmental-level agencies, including EPA and the U.S. Department of Labor's Occupational Safety and Health Administration, to address environmental hazards. To support this larger Federal effort, HHS will conduct targeted prevention and surveillance activities aimed at raising awareness of, monitoring, and mitigating threats. CDC and FDA will support this effort by using existing technologies and methods to measure the exposure to environmental chemicals in humans and the food supply. CDC also will investigate new technologies and methods to expand the number of chemicals measured in humans.

Childhood Lead Poisoning Prevention

CDC is addressing the problem of childhood lead poisoning through provision of funding and technical assistance to State and local childhood lead poisoning prevention programs. These programs are working to ensure that screening, lead-hazard reduction, model legislation, and other prevention mechanisms occur throughout the country. CDC will build on these efforts by developing and disseminating guidance for the proper treatment of children after they are identified as having elevated blood levels.

Violence Against Women

HHS has developed a Violence Against Women Steering Committee, which coordinates the HHS response to issues related to violence against women and their children. This committee, led by ASH, comprises representatives from ACF, AoA, CDC, FDA, HRSA, NIH, OPHS, the Office of the Secretary, and SAMHSA. The committee is also responsible for coordinating HHS violence-related activities with those of other Federal agencies. This steering committee will work to refine and focus HHS's activities on addressing violence against women. More information about HHS's efforts to address family violence can be found in *Strategic Goal 3, Objective 3.1*.

Youth Violence Prevention

CDC funds Academic Centers of Excellence to develop and implement community response plans to prevent youth violence. These Centers also train health professionals and conduct youth violence prevention research projects. CDC will continue funding these Centers. The agency also will identify modifiable risk factors that protect adolescents from becoming victims or perpetrators of violence and will increase public awareness regarding dating violence among adolescents through interactive programs such as *Choose Respect*.

Strategic Objective 2.3

Promote and encourage preventive health care, including mental health, lifelong healthy behaviors, and recovery.

Chronic diseases—such as heart disease, cancer, and diabetes—are among the leading causes of death and disability in the United States. These diseases account for 7 of every 10 deaths and affect the quality of life of 90 million Americans.[xxiii] Although chronic diseases are among the most common and costly health problems, they are also among the most preventable.

AHRQ, AoA, CDC, CMS, FDA, HRSA, IHS, OD, OPHS, and SAMHSA currently support a variety of programs and initiatives aimed at reducing the prevalence of chronic diseases and helping people with chronic conditions manage their diseases more effectively. State and local health departments, national and international health organizations, philanthropic foundations, and professional, voluntary, and community organizations are key partners in these health promotion and disease prevention activities. In the period of 2007–2012, these agencies will continue to support these activities and will work to expand, enhance, and improve their effectiveness. The Department selected key performance indicators that represent a broad array of activities, including cardiovascular health, cancer screening, and programs to reduce substance abuse and suicide.

Preventive Services

A paradigm shift has occurred in health care, resulting in a renewed emphasis on prevention. To reap the benefits of prevention, both health care providers and health care consumers must first understand what those benefits are. The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 (Public Law 108-173) expanded Medicare's menu of preventive benefits by covering an initial preventive physical examination. This benefit, also referred to as the "Welcome to Medicare" visit, allows new Medicare beneficiaries to get up-to-date information on important screenings and vaccinations, as well as to talk with their health care provider about

their medical history and how to stay healthy. All beneficiaries enrolled in Medicare Part B with effective dates that begin on or after January 1, 2005, will be covered for this benefit.

The *Welcome to Medicare* visit enables the health care provider to provide a comprehensive review of his or her patient's health, to identify risk factors that may be associated with various diseases, and to detect diseases early when outcomes are best. The health care provider is also able to educate his or her patient about the Medicare-covered services they need in order to prevent, detect, and manage disease; to counsel them on identified risk factors and possible lifestyle changes that could have a positive impact on their health; and to make referrals or followup appointments for necessary care. CMS will continue to support and conduct outreach related to the *Welcome to Medicare* benefit to increase beneficiaries' utilization.

Although Medicare pays for many critical preventive screenings, fewer than 1 in 10 adults aged 65 or older receive all recommended screenings and immunizations. CDC's *Healthy Aging Program* will continue to support a model program, *Sickness Prevention Achieved through Regional Collaboration* (SPARC), which has shown significant success in broadening the use of preventive services. SPARC promotes public access to services, helps medical practices provide preventive services, and strengthens local accountability for service delivery.

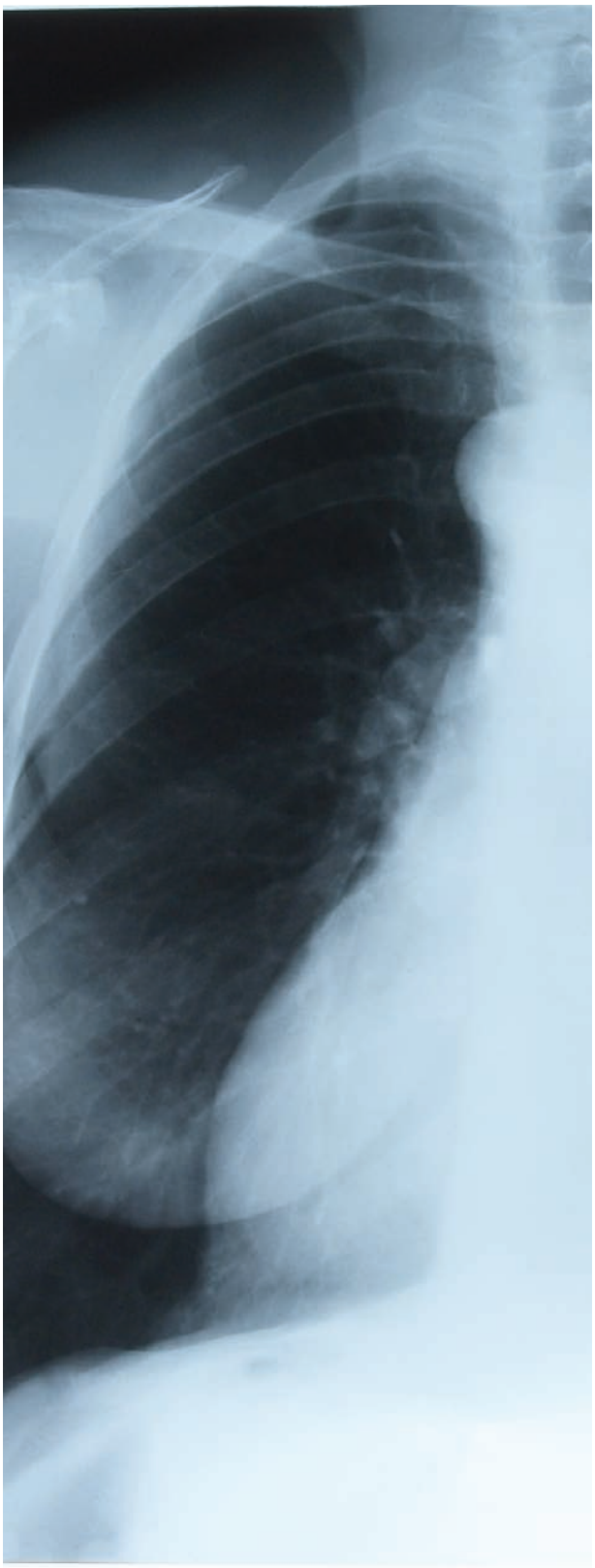
AHRQ accomplishes adoption and delivery of evidence-based clinical prevention services to improve the health of Americans through two main avenues: work in support of the United States Preventive Services Task Force (USPSTF) and Prevention Portfolio efforts aimed at dissemination and implementation of the Task Force's recommendations. As the USPSTF makes evidence-based recommendations, it is the job of AHRQ to get the word out to clinicians and the general public as rapidly as possible. Accomplishing this goal more quickly puts actionable information into the hands of clinicians, guiding them to perform indicated services and not to perform services for which the evidence indicates more harm than benefit. Getting the word out increases the delivery of appropriate clinical preventive services. Clinicians and policymakers across the Nation hold the work of the USPSTF in high regard.

Heart Disease and Stroke

Heart disease and stroke are the most common cardiovascular diseases. For both men and women in the United States, heart disease and stroke are the first and third leading causes of death, respectively, accounting for nearly 40 percent of annual deaths.[xxiv] Although these largely preventable conditions are more common among people 65 years or older, the number of sudden deaths from heart disease among people aged 15 years to 24 years has increased. The economic impact of cardiovascular disease on the Nation's health care system continues to grow as the population ages.

A key strategy for HHS in addressing heart disease and stroke and its risk factors is educating health practitioners and the public about the importance of prevention, about the signs and symptoms of heart attack and stroke, and about the importance of calling 911 quickly. To make women more aware of the danger of heart disease, the National Heart, Lung, and Blood Institute at NIH has collaborated with other organizations to sponsor a national campaign called *The Heart Truth*. The campaign's goal is to raise women's awareness about their risk of heart disease, and has resulted in striking improvements in women's awareness of heart disease and their acknowledgment of personal risk. CDC's *Heart Disease and Stroke Prevention Program* will continue to help States control high blood pressure and high blood cholesterol, both of which are risk factors for cardiovascular diseases, among residents; increase awareness of the signs and symptoms of heart attack and stroke; improve emergency response; improve quality of care; and eliminate health disparities. Medicare's preventive services cover cardiovascular disease screenings.

HHS will continue to provide national leadership to prevent death and disability from heart disease and stroke and to expand support to State cardiovascular disease prevention efforts. FDA also contributes to prevention of heart disease through its food labeling



regulations. For example, the recent requirement for trans-fat information on food labels provides consumers with additional information on the fat content of packaged foods. Reductions in consumption of trans-fatty acids are expected to reduce the risk of heart disease significantly.

Cancer

Cancer is the second leading cause of death in the United States and costs approximately $210 billion annually.[xxv] Cancer does not affect all racial or ethnic groups equally. African-Americans are more likely to die of cancer than any other racial or ethnic group, revealing a large health disparity related to this disease. CDC's *National Comprehensive Cancer Control Program* funds States, territories, and tribes to build coalitions, assess the burden of cancer, determine priorities, and develop and implement comprehensive cancer control programs. These programs help communities across the country to reduce cancer risks, detect cancers earlier, improve cancer treatment, and enhance quality of life for cancer patients. CDC is supporting these programs to ensure that cancer prevention and control reaches those at highest risk of developing cancer and in the greatest need of assistance.

CDC's *National Program of Cancer Registries* collects data on the occurrence of cancers through State and territorial registries. CDC is supporting cancer registries throughout the United States to enable public health professionals to better understand and address cancer and its causes.

Making cancer screening, information, and referral services available and accessible to all Americans is essential for reducing the high rates of cancer and cancer deaths. CDC's *National Breast and Cervical Cancer Early Detection Program* will continue to support screening and diagnostic exams for low-income women with little or no health insurance. The program will also support education and outreach, and case management services. CDC's prostate cancer control initiatives support information dissemination to the public, physicians, and policymakers about the risks and benefits of prostate cancer screening.

FDA advances cancer prevention through the development and licensure of cancer prevention vaccines.

Included in Medicare's menu of preventive services are screenings for colorectal and prostate cancer, as well as annual mammograms for women 40 years and older.

Overweight and Obesity

Over the last 20 years, rates for overweight and obesity have increased dramatically in the United States. Obesity has now reached epidemic proportions. CDC reports that two-thirds of noninstitutionalized U.S. adults age 20 and older are overweight or obese; a third are obese.[xxvi] The epidemic is not limited to adults, however. The percentage of young people who are overweight has more than doubled in the last 20 years. People who are obese are at increased risk for heart disease, high blood pressure, diabetes, and some cancers.

CDC, FDA, and OPHS are the primary HHS operating divisions working to reduce obesity and overweight in the United States, with a focus on improving nutrition and increasing physical activity. CDC will continue to support efforts to address obesity through provision of technical assistance, training, and consultation to funded State programs. CDC and its partners create, evaluate, and monitor programs, policies, and practices to prevent and control obesity. CDC will expand communication efforts to promote physical activity and good nutrition in worksites, schools, and health care settings.

FDA also contributes to obesity control through its food labeling regulations and education programs. For example, *Make Your Calories Count,* FDA's Web-based learning program, helps consumers make informed choices that contribute to lifelong healthy eating habits.

The OD physical fitness program, *I Can Do It, You Can Do It,* targets the obesity and overweight challenges of children and youth through physical exercise based on the awards system of the President's Committee on Physical Fitness and Sports Program. The program includes a mentee-mentor relationship and an evaluation component.

In addition, *Dietary Guidelines for Americans* provides science-based advice to promote health and to reduce risk for major chronic diseases and conditions, through diet and physical activity. Major causes of morbidity and mortality in the United States are related to poor diet and a sedentary lifestyle. Combined with physical activity, following a diet that does not provide excess calories, according to the recommendations in this document, should enhance the health of most individuals.

As a companion to the *Dietary Guidelines for Americans,* HHS will work over the next 2 years to develop comprehensive guidelines, drawn from science, to help Americans fit physical activity into their lives. The *Physical Activity Guidelines for Americans* will be issued in late 2008. The *Physical Activity Guidelines* will summarize the latest knowledge about activity and health, with depth and flexibility targeting specific population subgroups, such as older adults and children. This work is inspired by the President's personal dedication to physical fitness and his desire that every American have access to science-based guidelines.

Diabetes

In the last 15 years, the number of people in the United States with diagnosed diabetes has more than doubled, reaching 14.6 million in 2005.[xxvii] Diabetes, which is also associated with overweight and obesity, can cause heart disease, stroke, blindness, kidney failure, pregnancy complications, lower extremity amputations, and deaths related to influenza and pneumonia. In addition to the millions of Americans with diabetes, an estimated 41 million adults aged 40 to 74 are prediabetic and are at high risk of developing diabetes.[xxviii] The increasing burden of diabetes and its complications is alarming. However, much of this burden could be prevented with early detection, improved delivery of care, and better education on diabetes self-management.

CDC monitors the burden of diabetes nationally and will continue to explore better ways to collect diabetes data on groups most at risk. CDC also provides funding for capacity building and program implementation to States and territories for diabetes prevention and control programs. Over the next 5 years, CDC will expand the number of implementation grants after first developing grantee capacity through phase one capacity grants.

CDC also works with NIH to support diabetes education. These operating divisions will continue to collaborate to enhance the network of more than 200 public and private partners who work to increase knowledge about diabetes and its control among health care providers and people with or at risk for diabetes. IHS also will support diabetes prevention and control through mobilizing and involving American Indian/Alaska Native communities to promote diabetes management strategies. For Medicare beneficiaries diagnosed with prediabetes and those previously tested who have not been diagnosed with prediabetes, or those who have never been tested for the disease, diagnostic screening tests are available. For Medicare beneficiaries with diabetes, Medicare offers *Diabetes Self-Management Training and Medical Nutrition Training.*

Oral Health

Mouth and throat diseases, which range from cavities to cancer, cause pain and disability for millions of Americans each year. This fact is disturbing because almost all oral diseases can be prevented. For children, cavities are a common problem that begins at an early age. Tooth decay is also a problem for U.S. adults, especially for the increasing number of older adults who have retained most of their teeth. Despite this increase in tooth retention, tooth loss remains a problem among older adults.

CDC is the lead Federal agency responsible for promoting oral health through public health interventions. CDC has and will continue to assist States in strengthening their oral health programs, reaching people hardest hit by oral diseases, and expanding the use of measures that are proven effective in preventing oral diseases. CDC currently provides 12 States with funds, technical assistance, and training to build strong oral health programs. Eight of the 12 States receive funding to develop and coordinate

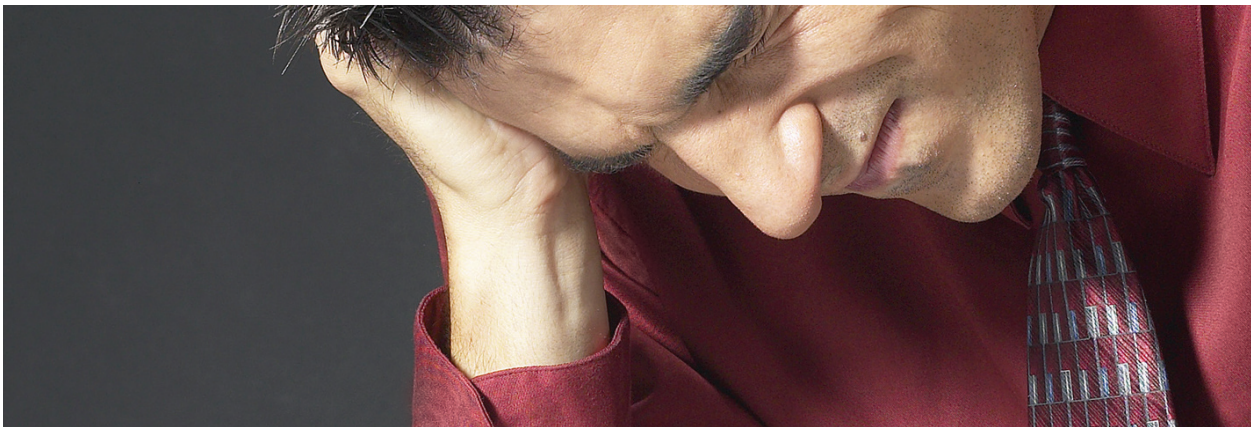
community water fluoridation programs or school-based dental sealant programs. With CDC support, States can better promote oral health, monitor oral health behaviors and problems, and conduct and evaluate prevention programs.

Substance Use/Abuse

The use of alcohol, tobacco, and illicit drugs exacts a significant health and economic toll on individuals and communities in the United States. In 2005, 19.7 million (8.1 percent) Americans aged 12 years and older used an illicit drug, 71.5 million (29.4 percent) used a tobacco product, and 126 million (51.8 percent) used alcohol.[xxix] Tobacco use is the leading preventable cause of death in the United States, resulting in approximately 440,000 deaths each year.[xxx]

CDC supports basic implementation programs to prevent and control tobacco use in the States, territories, and tribal areas. CDC also works with a variety of national and international partners to promote action through partnership in tobacco control efforts with WHO and WHO Member States. Building on these existing activities and partnerships, CDC will work to engage business sectors in supporting comprehensive tobacco prevention and control programs, including the benefits of tobacco-free workplaces and the importance of access to cessation services to employees who are trying to quit smoking. For Medicare beneficiaries who use tobacco, cessation counseling is a covered preventive service.

As part of its efforts to reengineer its approach to substance abuse prevention, SAMHSA has created a strategic framework that is built on science-based theory, evidence-based practices, and the knowledge that effective prevention programs must engage individuals, families, and entire communities. SAMHSA's new *Strategic Prevention Framework* (SPF) sets into place a step-by-step process that empowers States and communities to identify their unique substance use problems, build or enhance infrastructure to support solutions, and implement the most effective prevention efforts for their specific needs. It also includes monitoring and evaluation to ensure accountability



and effectiveness of the program effort. SAMHSA will continue to utilize the SPF and expand its use through its State and local grant programs.

Suicide Prevention

For every two victims of homicide in the United States, there are three Americans who take their own lives. Suicide is a potentially preventable public health problem. Studies of youth who have committed suicide have found that 90 percent had a diagnosable mental and/or substance abuse disorder at the time of their death.[xxxi] SAMHSA supports activities authorized by the Garrett Lee Smith Memorial Act of 2004 (Public Law 108-355), which support statewide youth suicide intervention and prevention strategies in schools, institutions of higher education, juvenile justice systems, substance abuse and mental health programs, foster care systems, and other youth support organizations. Additionally, OD is working on an initiative to understand and help prevent suicide among persons with disabilities and those who incur disabilities.

Risk Reduction

Chronic conditions currently limit activities for 12 million older people living in community settings in the United States; 25 percent of these individuals are unable to perform basic activities of daily living, such as bathing, shopping, dressing, or eating. Furthermore, falls are the leading cause of injury-related deaths and hospital admission among older people and account for between 20 billion and 30 billion health care dollars in the United States each year. These numbers will increase dramatically in the coming years with the aging of the Baby Boom Generation. AHRQ, AoA, CDC, CMS, and NIH contribute to research, demonstrations, the setting of national standards and guidelines, and the provision of grants and technical assistance to help older adults manage their chronic diseases and prevent falls and to encourage them to live healthy and active lifestyles.

For example, AoA funds an *Evidence-Based Disability and Disease Prevention* grant program and public/private partnership which deploys proven disability and disease prevention programs at the community level that empower older individuals to make behavioral changes that will reduce their risk of disease, disability, and injury. AHRQ and AoA, in collaboration with CDC, CMS, and NIH, are developing and testing a special Knowledge Transfer program targeted at State and local agency staff to promote and facilitate the utilization of evidence-based disease prevention programs for older people at the community level. CDC funds fall prevention research, research dissemination, and research translation and implementation that help decrease falls and increase stability in mobile older adults. CMS is demonstrating a health promotion and disease prevention program through the *Medicare Senior Risk Reduction Demonstration* to determine whether health risk reduction programs that have been developed, tested, and shown to be effective in the private sector can be tailored to the Medicare program to help beneficiaries improve their health and thus reduce the need for health care services.

Strategic Objective 2.4

Prepare for and respond to natural and manmade disasters.

The Pandemic and All-Hazards Preparedness Act of 2006 (PAHPA; Public Law 109-417) codified the HHS Secretary's role as lead for the Federal public health and medical response to emergencies and incidents covered by the National Response Plan (NRP), and authorizes HHS's operational control of Federal public health and medical response assets during these events.[8] In addition, the development of the Homeland Security Council's *National Strategy for Pandemic Influenza* has stressed the importance of preparedness for natural and manmade disasters that have public health impact. Many of the strategies undertaken by HHS to achieve preparedness and response capability are done in concert with or in support of other Federal departments and agencies, State and local governments, and private sector entities. This collaborative approach is vital given that public health emergencies have the potential to affect nearly every sector of society. One of HHS's largest investments is to develop and stockpile the countermeasures needed to respond to the most serious disasters. Consequently, a performance indicator listed at the end of this chapter assesses the readiness of States to utilize these supplies. A second indicator focuses on the extent to which State emergency management plans cover the broad array of individuals with special needs, specifically measuring plans for those with disabilities.

The Office of the Assistant Secretary for Preparedness and Response (ASPR) is the single office responsible for preparedness and response activities within HHS. As the principal advisor to the Secretary on all matters related to public health and medical preparedness and response emergencies, ASPR leads and promotes a collaborative approach with many partners, including ACF, AoA, CDC, CMS, FDA, HRSA, OPHS, and SAMHSA. For additional information on this topic, see *In the Spotlight: Emergency Preparedness, Prevention, and Response.*

8 An exception to this authorization is those assets under the control of the U.S. Department of Defense.

Key strategies that will be used to enhance public health and medical emergency preparedness and response include:

- Developing the National Health Security Strategy, starting in 2009;
- Awarding cooperative agreements to States or other eligible entities to conduct the activities of the National Health Security Strategy; and
- Reintegrating the National Disaster Medical System within HHS.

A major focus of preparedness activities will be the implementation of the *Biomedical Advanced Research and Development Authority* (BARDA), and countermeasures development. The international preparedness activities include the *International Health Regulations,* which will come into force in June 2007. These regulations require members to develop, strengthen, and maintain core surveillance and response capacities to detect, assess, notify, and report public health events to WHO and respond to public health risks and public health emergencies. WHO, in turn, will evaluate members' public health capacities, promote technical cooperation, offer logistical support, and facilitate the mobilization of financial resources for building capacity in surveillance and response.

Workforce Readiness

HHS will identify, put on a roster, and train deployable teams of medical and public health providers, including HHS personnel (both commissioned officers and civil service employees), other Federal employees, and voluntary staff. HHS meets regularly with its ESF-8[9] Federal partners to identify missions, form teams with the skills needed to meet the missions, identify training and equipment requirements, and initiate

9 *Emergency Support Function (ESF)-8—Health and Medical Services.* ESF-8 provides coordinated Federal assistance to supplement State and local resources in response to public health and medical care needs after a major disaster or emergency, or during a developing potential medical situation. Assistance provided under ESF-8 is directed by HHS through its executive agent, ASPR.

training. HHS has identified the logistical support needs for these teams and has developed specific tasks for meeting these logistical needs. Examples of these needs include medical supplies, equipment, housing, and food requirements.

This activity builds upon the transformation activities of the Commissioned Corps of the USPHS (Commissioned Corps). The Commissioned Corps provides a unique source of well-trained, highly qualified, dedicated public health professionals who are available to respond rapidly to urgent public health challenges and health care emergencies. The Commissioned Corps' response to Hurricane Katrina is a powerful example of what its officers can do. In response to Hurricane Katrina, the Commissioned Corps deployed more than 2,000 officers—the largest deployment in its history—and still has personnel in the field providing care in Louisiana today. The transformation will facilitate force management improvements that are necessary for the Commissioned Corps to function even more efficiently and effectively. The current activity using rosters is aimed at structuring officers into teams, and then training them as a team. This approach defines clarity of roles and expectations, and assures that leadership and management of the officers in the deployed situation are well understood and their roles are executable.

These teams will interface with the Disaster Medical Assistance Teams (DMATs) fielded under the *National Disaster Medical System* (NDMS). The greatest utility of the DMATs is in immediate emergency response, and they are considered the initial responders for emergency medical needs during the first 72 hours after an event. HHS and other Federal agencies will be responsible for the other requirements in the continuum of health needs, including some aspects of health services delivery during evacuation, hospital care, low-intensity facility-based care for populations with special needs (such as chronic diseases and disability), and other health outreach activities.

Threat Agent Identification

CDC and FDA will continue to develop and support laboratory capacity expansion to improve analysis of biological or toxic substances that uses validated, proven methods for different sample matrices. CDC and FDA will also support the development and validation of laboratory methods for priority biological and toxic substances through the *Laboratory Response Network.*

Emergency Preparedness

HHS administers two major grant programs that support State and local capacities, as well as capabilities to prepare for and respond to public health emergencies. Over the next 5 years, these programs will shift dramatically, from a focus on capacity building to improving targeted capabilities.

ASPR administers the *National Bioterrorism Hospital Preparedness Program,* which, through States, enhances the ability of the health care system, including hospitals, to prepare for and respond to bioterrorism and other public health emergencies. Program priority areas over the next 5 years include improving bed and personnel surge capacity, decontamination capabilities, isolation capacity, and pharmaceutical supplies, as well as supporting training, education, drills, and exercises.

CDC administers the *Public Health Emergency Preparedness Cooperative Agreement Program,* which provides funds to States and localities for State and community-level preparedness. Over the next 5 years, HHS will place increased emphasis on achieving benchmarks and standards for preparedness by recipients of both funding streams as required by PAHPA.

Countermeasures

HHS, through all of its operating divisions, seeks to shape and execute a comprehensive medical countermeasures program to protect our citizens against the threats of today and into the future. This mission encompasses the breadth of activities required to accomplish that goal, including threat agent monitoring and disease surveillance and detection, as well as research, development, acquisition,

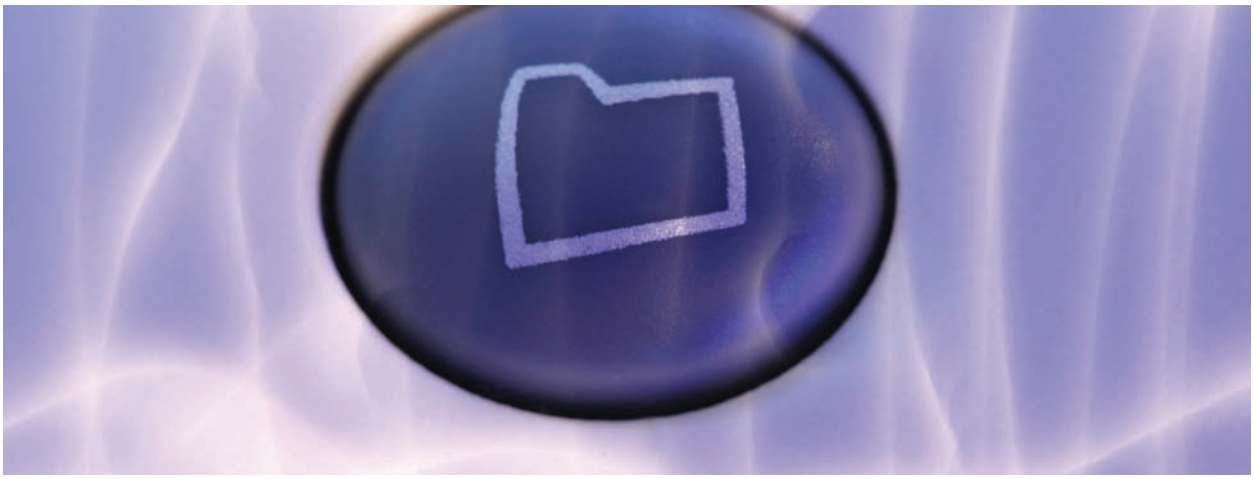
storage, deployment, and utilization of medical countermeasures. NIH leads the effort for medical countermeasure basic research, early stage product development, and clinical research. FDA is committed to facilitating the development and availability of safe and effective medical countermeasures. CDC has responsibilities including disease monitoring through its infectious disease surveillance program and medical countermeasure storage and deployment through its *Strategic National Stockpile* (SNS) program. The SNS procures and stores large quantities of medicine and medical supplies to protect the American public if there is an emergency (e.g., terrorist attack, influenza pandemic, or earthquake) severe enough to cause local supplies to run out. HHS will continue to invest in research and development of medical countermeasures, procure safe and effective materials for the SNS, and work with States to ensure that they are prepared to request, receive, and utilize SNS materials in the case of a public health emergency.

Pandemic Influenza

HHS pandemic influenza implementation activities support the larger *National Strategy for Pandemic Influenza,* and many are conducted in concert with or in support of other Federal departments and agencies. The key strategies for pandemic influenza preparedness focus on international activities; domestic surveillance; public health interventions; medical response; vaccines, antivirals, diagnostics, and personal protective equipment; passive and active surveillance for vaccine safety; communication; and support for State, local, and tribal preparedness. HHS, primarily through ASPR, CDC, FDA, NIH, and OPHS, will continue to support the *National Strategy* by completing actions in these strategy areas. One major area of focus will be building the prepandemic and pandemic influenza vaccine production capacity and vaccine supply. In April 2007, FDA approved the first U.S. vaccine for humans against the H5N1 influenza virus. FDA will continue to facilitate advanced product development of both seasonal and pandemic influenza medical countermeasures, including novel vaccines, antivirals, and rapid diagnostics. This will be accomplished by providing assistance to industry partners on domestic manufacturing capabilities, accelerating the reviews of seasonal and pandemic influenza related products, and issuing guidance to external stakeholders on various regulatory subjects, including clinical requirements for licensure of seasonal and pandemic influenza vaccines. HHS agencies also will work closely with other Federal agencies and international partners, such as WHO and the ministries of health in target countries. HHS has forward-deployed a quantity of Tamiflu in Asia for the purposes of mounting a containment operation to attempt to halt a potential influenza pandemic. In addition, HHS is engaged in a number of international pandemic preparedness activities, through the *International Partnerships on Avian and Pandemic Influenza,* the *Security and Prosperity Partnership of North America,* and the *Global Health Security Initiative.*

People With Disabilities

Under Executive Order 13347, all Federal emergency preparedness efforts must address the needs of individuals with disabilities and other vulnerable populations. HHS has taken a leadership role in engaging the disability community and providing guidance to partners to address the unique health needs of individuals with disabilities and other vulnerable populations, including children and youth with special health care needs. In 2006, HHS and the U.S. Department of Homeland Security cosponsored a working conference for State emergency preparedness, public health, aging, and disability agencies to facilitate dialog and collaboration among these organizations toward the common goal embodied in the Executive Order. The result has been a living laboratory for State and Federal cooperation and shared learning around the issue of emergency preparedness for vulnerable populations. OD and ASPR will implement and monitor the use of the disability-based preparedness toolkit and public health staff training modules—developed by a broad-based HHS workgroup—to ensure that the needs of children, youth, and adults with disabilities and chronic conditions are fully understood by first responders and other emergency response providers at the Federal, tribal, State, and local levels during all emergency situations.



ASPR, OD, and OCR are working with the American Red Cross to develop an intake and assessment tool that will be used at shelters to evaluate the functional needs of all individuals, including individuals with disabilities. This tool will help ensure that individuals with disabilities have equal access to shelter services and are served in the most integrated setting appropriate. On the local level, OCR's 10 regional offices are working with other offices in HHS and States to provide technical assistance and resources to plan for and respond to needs of individuals with disabilities in the event of an emergency.

Protected Health Information. In its review of State and local emergency plans issued in the summer of 2006, the U.S. Department of Homeland Security identified misunderstanding and confusion surrounding the application of the HIPAA Privacy Rule protections to information sought for emergency response planning purposes. OCR has implemented a new Web-based interactive decision tool designed to assist emergency preparedness and recovery planners in determining how to access and use health information consistent with the HIPAA Privacy Rule. The tool guides emergency preparedness and recovery planners through a series of questions regarding how to apply the HIPAA Privacy Rule. The tool is available on OCR's Web site along with bulletins containing information for emergency providers on the disclosure of protected health information to assist with disaster relief efforts.

Equal Access

OCR has taken steps, consistent with a Federal Governmentwide effort, to help ensure that individuals with Limited English Proficiency (LEP) have equal access to information, shelters, and other evacuation and relief efforts. For example, OCR is working with ASPR and the American Red Cross to develop an intake and assessment tool that will be used at shelters to identify and address communication needs of individuals with LEP. On the local level, OCR's regional offices are working with HHS partners and States to provide technical assistance and resources to plan for and respond to the needs of individuals with LEP in the event of an emergency.

Information Technology Support

HHS will be developing a deployable, interoperable first responder electronic health record system. The electronic health record system for disasters will maintain the security and confidentiality of health information. The intention is to field test possible platforms during the 2007 hurricane season to gain insight into their benefits and limitations. There are few existing systems and standards in the broader health environment to interact with at this time, so the expected benefits are to ensure quality of care and continuity of information sharing during a public health emergency and its aftermath. Wider health sector standards development and endorsement by the Health Information Technology Standards Panel and the Secretary will be completed to capitalize on the desired benefits of this approach toward continuity and quality of care.

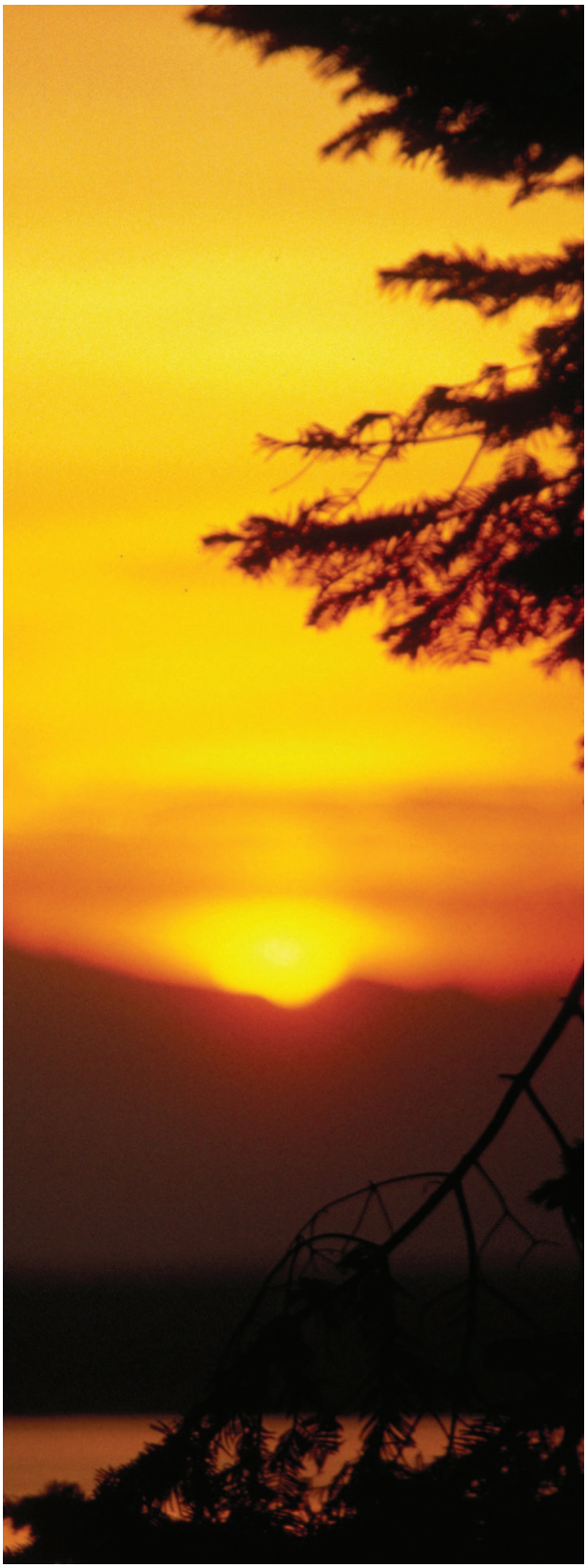
Performance Indicators

		Most Recent Result	FY 2012 Target
Strategic Objective 2.1 Prevent the spread of infectious diseases.			
2.1.1	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).	a) DTaP: 86%; b) Polio: 92%; c) MMR: 92%; d) Hepatitis B: 93%; e) Hib: 94%; f) Varicella: 88%; and g) PCV7: 83%.	At least 90%
2.1.2	Increase the proportion of people with HIV diagnosed before progression to AIDS.	76.5%	81%
2.1.3	Reduce the incidence of infection with key foodborne pathogens: a) Campylobacter; b) Escherichia coli O157:H7; c) Listeria monocytogenes; and d) Salmonella species.	Cases/100,000: a) 12.72; b) 1.06; c) 0.30; and d) 14.55.	Cases/100,000: a) 12.30; b) 1.00; c) 0.23; and d) 6.80.
2.1.4	Increase the rate of influenza vaccination: a) in persons 65 years of age and older; and b) Among noninstitutionalized adults and high risk, aged 18 to 64.	a) 59.6%; and b) 25.3%.	a) 90%; and b) 60%.

		Most Recent Result	FY 2012 Target
Strategic Objective 2.2 **Protect the public against injuries and environmental threats.**			
2.2.1	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.	a) 4.4/100 FTE[10]; and b) 2.7/100,000 FTE.	a) 4.2/100 FTE; and b) 2.8/100,000 FTE
Strategic Objective 2.3 **Promote and encourage preventive health care, including mental health, lifelong healthy behaviors, and recovery.**			
2.3.1	Reduce complications of diabetes among American Indians and Alaska Natives by increasing the proportion of patients with diagnosed diabetes that have achieved blood pressure control (<130/80).	37%	50%
2.3.2	Increase the proportion of women aged 40 years and older who received a mammogram within the preceding 2 years.	74.6%	77%
2.3.3	Reduce 30-day use of illicit substances (age 12 and older).	7.9%	5.8%
2.3.4	Reduce the number of suicide deaths.	32,439	30,584
Strategic Objective 2.4 **Prepare for and respond to natural and manmade disasters.**			
2.4.1	Increase the percentage of State public health agencies prepared to use materiel contained in the Strategic National Stockpile (SNS).	70%	90%
2.4.2	Increase the number of States and territories that include persons with disabilities in emergency management plans and responses.	6	55

Note: Additional information about performance indicators is included in Appendix B.

10 FTE = full-time equivalent employee, and one FTE = 2,000 hours worked (average hours worked by a full-time employee in a year).



Meeting External Challenges

Within the *Public Health Promotion and Protection, Disease Prevention, and Emergency Preparedness* goal, changes in population demographics, shifts in burden of disease, uncertainty related to the scope and timing of public health emergencies, and the potential threat of zoonotic diseases will significantly influence the ability of HHS to achieve the objectives related to this goal.

As the Nation's population ages, a greater proportion of Americans will be older and expected to live longer. These shifts will result in an increased chronic disease burden and a greater need for public health interventions to prevent or control these diseases. HHS will work to mitigate these effects by promoting the translation of the evidence base for health promotion and disease prevention for older adults at the community level. HHS also will continue to develop and implement cost-effective models to support increasingly frail older adults in their homes.

A shifting distribution in disease burden also affects the ability of HHS to achieve its public health objectives. For example, HIV-related disease and affected populations will result in an expansion of the number of HIV-infected individuals who need treatment and related care. Infections in new subpopulations could be difficult to identify, reach, and serve. HHS is developing improved disease surveillance and outreach strategies to identify and reach newly affected populations in the United States. HHS also is providing assistance to service providers in planning and capacity-building efforts to meet these changes.

In the public health emergency preparedness arena, external factors represent both threats and opportunities. First, the unexpected scope of emergencies in terms of probability of occurrence, place, time, and type makes resource allocation and targeting a significant challenge. A hurricane can result in significant public health consequences as Hurricane Katrina did in 2005, or may result in little or no health impact. A bioterrorist attack could be widespread, occur simultaneously in multiple locations, or be limited to one room in one building. HHS is addressing

this uncertainty by planning for multiple scenarios in its all-hazards preparedness program. HHS also is providing guidance to help States and localities enhance their capacity to respond to natural or manmade disasters of varying severity and scope. Second, external factors also provide opportunities for shared planning, response, and evaluation. By working with our Federal, State, local, and tribal partners, we can leverage resources and personnel to improve overall level and quality of both preparedness and response.

Emerging pathogens, many of which are zoonotic in origin, also affect emergency preparedness. Because the habitats of animals and people are inextricably linked, there is an increased possibility for exposure to zoonotic diseases. HHS understands this link, and is coordinating strategies to mitigate zoonotic diseases that originate in animals in order to protect both animal and human health. HHS collaborates with other Federal departments and agencies and international organizations that focus on animal health, as well as with State governments and academic institutions, to address zoonotic diseases.

Public Health/Medical Emergencies

The last several years have seen an increased emphasis on preparing for and responding to public health emergencies. The September 11, 2001, terrorist attacks and the anthrax incidents later that year generated significant change at the Federal, State, and local levels in terms of public health law, infrastructure, programming, and coordination to address preparedness and response issues. Infectious disease outbreaks such as SARS and the fear of an influenza pandemic have only amplified interest in public health preparedness.

The range of potential public health emergencies is broad—terrorist attacks using chemical, biological, radiological, and nuclear agents; emerging and reemerging infectious diseases; accidental contamination of food and water supplies; and natural disasters, including hurricanes, earthquakes, and tornadoes. The varying nature and scope of public health emergencies requires an all-hazards approach to planning and response.

Preparedness at All Levels

HHS serves as the primary agency for Emergency Support Function (ESF)-8— preparedness and response to the health consequences of disasters, including terrorist incidents involving weapons of mass destruction—under the *National Response Plan* (NRP). The NRP is designed to engage the response assets of multiple public and private partners and bring them to bear in a coordinated way at one or a few incident sites. HHS conducts the ESF-8 activities in support of the Federal incident management system, led by the U.S. Department of Homeland Security in its role as the domestic incident manager, pursuant to Homeland Security Presidential Directives and the Homeland Security Act of 2002 (Public Law 107-296).

Carrying out HHS's responsibility as the primary agency for medical and public health preparedness requires the diverse and unique skills of scientists, public health experts, and health care providers at AHRQ, CDC, FDA, HRSA, NIH, OCR, OD, and SAMHSA. Given the complexity of and need for coordination around these preparedness activities, HHS has created a coordination and oversight function for emergency preparedness within the Office of the Secretary. The Office of the Assistant Secretary for Preparedness and Response (ASPR) focuses the activities of these operating and staff divisions, develops and coordinates national policies and plans, provides program oversight, and is the Secretary's public health emergency representative to other Federal, State, and local organizations.

Although significant preparedness activities are undertaken at the Federal level, States and localities are primarily responsible for responding to public health emergencies in their jurisdictions. HHS conducts basic and applied research to improve planning for and service provision in public health emergencies. HHS also offers technical assistance, guidance, and funding support to State and local governments to aid in the development and implementation of public health emergency preparedness plans.

Framework for Preparedness

HHS leads the Federal public health and medical emergency response to acts of terrorism or nature and to other public health and medical emergencies. ASPR is responsible for ensuring that HHS's family of agencies work together to develop public health and medical preparedness and response capabilities and that they lead and coordinate the relevant activities of the HHS operating divisions.

Preparedness strategies focus on ensuring that individuals, families, vulnerable populations, and communities are prepared for public health emergencies and disasters. Response strategies focus on promoting resiliency and responsibility in communities and among the citizenry in response to a public health emergency.

These strategies include:

Developing and using policies and plans. HHS is developing national and Departmental policies and plans for response to public health and medical threats and emergencies. Areas of planning include developing and maintaining the *National Health Security Strategy,* a coordinated strategy, and the implementation plan for public health emergency preparedness and response that includes an evaluation of progress of Federal, State, local, and tribal entities, based on evidence-based benchmarks and objective standards that measure levels of preparedness. This response also includes developing a strategic plan to integrate biodefense and emerging infectious disease requirements with advanced research and development, strategic initiatives for innovation, and the procurement of qualified countermeasures (within the purview of the Biomedical Advanced Research and Development Authority, or BARDA[11]).

Aligning resources and building partnerships. HHS is aligning Departmental entities to support the ASPR preparedness, prevention, and response mission and is building productive strategic partnerships—at the domestic and international levels, within the private and public sectors—to combat bioterrorism and other public health threats and emergencies.

Coordinating emergency preparedness and response activities. Activities include coordinating the acceleration of advanced research, development, and procurement of qualified countermeasures, including pandemic or epidemic products (within the purview of BARDA). HHS also coordinates public health and medical response systems with relevant Federal, State, local, and tribal officials and with the *Emergency Medical Assistance Compact* to ensure integration of preparedness and response activities for public

11 This agency would lead in the development of new medical countermeasures against bioterrorism and natural disease outbreaks.

health emergencies. HHS also works to ensure that the *National Disaster Medical System* (NDMS),[12] the *Medical Reserve Corps* (MRC),[13] and the *Emergency System for Advanced Registration of Volunteer Health Professionals* (ESAR-VHP)[14] are properly coordinated to maximize and streamline the response to public health emergencies.

Enhancing response personnel capacity. This process begins with establishing and maintaining a *Medical Reserve Corps* to provide for an adequate supply of volunteers in the case of a Federal, State, local, or tribal public health emergency. HHS is also developing core health and medical response curriculums and training to improve responses to public health emergencies.

Enhancing preparedness through leadership and support. HHS efforts enhance State and local public health and medical preparedness—primarily health departments and hospitals, providing expert medical, scientific, and public health leadership and advice. HHS also leads international programs, initiatives, and policies that deal with public health and medical emergency preparedness and response related to naturally occurring threats such as infectious diseases and deliberate threats from biologic, chemical, nuclear, and radiation sources. In addition, the Department awards contracts, grants, and cooperative agreements, or enters into other transactions, such as prize payments, to promote innovation in technologies that may assist countermeasures and produce advanced

12 The NDMS is a federally coordinated system that augments the Nation's medical response capability. The overall purpose is to establish a single integrated national medical response capability for assisting State and local authorities in dealing with the medical impacts of major peacetime disasters and to provide support to the military and the VA medical systems in caring for casualties evacuated back to the United States from overseas armed conventional conflicts.

13 The MRC establishes teams of local volunteer medical and public health professionals who can contribute their skills and expertise throughout the year and during times of community need.

14 ESAR-VHP works to establish standardized volunteer registration systems within each State and in the territories that will include readily available, verifiable, and up-to-date information of the volunteer's identity, licensing, credentialing, accreditation, and privileging in hospitals or other medical facilities that might need volunteers. Establishment of these nationally accepted guidelines to build their State systems would afford each State the ability to quickly identify, and better utilize, health professional volunteers in emergencies and disasters.

research and development; conducts research on and develops research tools and other devices and technologies; and supports research to promote strategic initiatives (within the purview of BARDA). HHS also awards competitive grants or cooperative agreements to support the improvement of surge capacity and enhancement of community and hospital preparedness for public health emergencies.

Protecting vulnerable populations. HHS ensures that State and local emergency plans include attention to persons with disabilities in all emergency management plans and responses.

Providing support in emergencies. HHS rapidly provides public health and medical support to Federal, State, local, and tribal incidents of national significance or public health and medical emergencies.

Establishing the Public Health Emergency Medical Countermeasures Enterprise. HHS has developed a strategy for the *Public Health Emergency Medical Countermeasures Enterprise.* The ultimate goal is to establish the foundational elements that will support medical countermeasure availability and utilization for the highest priority chemical, biological, radiological, and nuclear threats facing the Nation.

Establishing a nationwide situational awareness. HHS is working to develop and implement a near-real-time electronic nationwide public health situational awareness capability through an interoperable network of systems to enhance early detection of, rapid response to, and management of potentially catastrophic infectious disease outbreaks and other public health emergencies.

HHS's Mandate

The mandate of the U.S. Department of Health and Human Services is to protect the health of the American people. Events in recent years, however, have made it clear that our efforts to protect Americans' health cannot end at our borders.

Pathogens and other threats to human health are as mobile as we are, and have become more and more dangerous through growing drug resistance and natural mutations. As the world's population becomes increasingly mobile, and as diseases change, our own health becomes more and more intertwined with the world's health.

The health of other nations is also closely tied to economic productivity, social stability, and good governance. Such economic, social, and political realities clearly intersect with our national interest, and further compel us to address a variety of global health concerns.

Health-related programming can also hold a special place as a foreign-policy tool for the U.S. Government. Our work to improve global health demonstrates the generosity of the American people. Given the universal value populations place on good health, evidence-based, public-health interventions can help to transcend political boundaries.

Meeting its Mandate

HHS works to improve global health through direct assistance, technical and program support, training and capacity building, and through research.

Within HHS, CDC works to detect, verify, and quickly respond to outbreaks of infectious diseases around the globe and to control other health threats at their origin to prevent international spread. To maintain the safety of the American people, FDA regulates millions of products produced abroad. NIH addresses global health challenges through innovative, collaborative research and training programs, and through international partnerships. SAMHSA works with postconflict and postdisaster countries to enable stakeholders to work together to address the mental health needs of their peoples. It also helps to administer programs to train and support mental health professionals from developing nations. Building on its leadership of the domestic Ryan White HIV/AIDS Program, HRSA provides training and quality improvement interventions in the *President's Emergency Plan for AIDS Relief* (PEPFAR).

HHS has a significant international presence. HHS staff—both civil servants and USPHS officers—serve around the globe. These dedicated professionals work to improve the health of the world—through their work on PEPFAR, the *President's Malaria Initiative* (PMI), the *Global Polio Eradication Initiative* (GPEI), or through work to encourage innovative, cooperative biomedical research with researchers from other countries. HHS also regularly sends its staff to work as health attachés in U.S. Embassies and Missions abroad. These health attachés represent the U.S. Government to host-country ministries of health and to international organizations such as WHO.

Achievements

Through its work in international health, HHS boasts a number of significant accomplishments. In the first 3 years of PEPFAR, in 15 focus countries in Africa, Asia, and the Caribbean, HHS, through the efforts of CDC, FDA, and HRSA, has played a significant role in the U.S. Government's support of antiretroviral treatment for 820,000 people living with HIV/AIDS. In its role in PEPFAR, HHS has also joined the U.S. effort in supporting care for almost 4½ million people, including 2 million orphans and vulnerable children, as well as counseling and testing for 18.6 million people.

In the first year of PMI, which HHS and the United States Agency for International Development (USAID) implement jointly, PMI delivered life-saving interventions to prevent and control malaria in the first three countries (Angola, Tanzania, and Uganda). Nearly 1 million long-lasting insecticide-treated bed nets (ITNs) were distributed; approximately half a million ITNs that were not long lasting were re-treated; more than 2 million people were protected from malaria after the interiors of their homes were sprayed with insecticides; and approximately 1.2 million treatments of artemisinin-based combination therapy were procured and distributed.

Through CDC's participation in the GPEI, HHS has played a significant role in spearheading the global fight to eradicate polio. At the launch of the GPEI in 1988, polio was endemic in more than 125 countries, and paralyzed 350,000 children each year. In 2006, only 1,985 people were paralyzed by polio, and now, only 4 endemic countries remain. CDC continues to provide significant technical expertise and support to governments and international organizations in the fight to eradicate polio.

HHS, through the work of CDC, is a core partner in the global *Measles Initiative,* which also includes the American Red Cross, United Nations Foundation, United Nations Children's Fund, and WHO. The work of this initiative has had a significant effect on measles deaths globally. Such deaths have fallen by 60 percent worldwide, from an estimated 873,000 deaths in 1999, to 345,000 in 2005. In Africa, measles deaths fell by 75 percent, from an estimated 506,000 to 126,000 in that same period. A concerted initiative in the Americas since 2002 has eliminated endemic measles from the Western Hemisphere.

Interagency Efforts

We also know that we cannot achieve our global health goals alone. In our work, HHS partners with many other Departments, including the U.S. Departments of State, Defense, Agriculture, Homeland Security, and Commerce. HHS also collaborates closely with USAID and with EPA. HHS also enjoys excellent bilateral partnerships with other governments, as well as good working relationships with multilateral organizations, nongovernmental and faith-based organizations, and with the private sector.

HHS is also committed to working to achieve several of the Millennium Development Goals (MDGs) developed by the United Nations. Eight MDGs were developed in September 2000 at the United Nations Millennium Summit to help provide a framework for leaders to improve the health and well-being of men, women, and children around the world. The intent is to make significant improvement in these areas by 2015. Of the MDGs developed, HHS is particularly focused on MDG 4 (reduce child mortality), MDG 5 (improve maternal health), and MDG 6 (combat HIV/AIDS, malaria, and other diseases).

Important as international health may be today, addressing its challenges will be crucial in the future. If the U.S. Government is to continue its leadership in global affairs, it must continue to foster these high-tech, public health instruments for engaging the world, both to mitigate global health risks and to strengthen U.S. public diplomacy abroad.

Chapter 4

Strategic Goal 3: Human Services

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

Welfare reform stands as a flagship achievement in social policy reform in the mid-1990s. Through welfare reform, many Americans were helped in breaking the cycle of dependency and encouraged to pursue self-sufficiency. Since the reforms were passed in 1996, the employment rates of current and former welfare recipients have risen and caseloads have declined dramatically. Earnings for current welfare recipients have increased, as have earnings for female-headed households in general. In addition, child poverty rates have declined substantially since the start of the Temporary Assistance for Needy Families (TANF) program. States are using their flexibility to focus a growing portion of welfare dollars on helping individuals retain jobs and advance in their employment.

STRATEGIC GOAL 3: HUMAN SERVICES

Strategic Objective 3.1:
Promote the economic independence and social well-being of individuals and families across the lifespan.

Strategic Objective 3.2:
Protect the safety and foster the well-being of children and youth.

Strategic Objective 3.3:
Encourage the development of strong, healthy, and supportive communities.

Strategic Objective 3.4:
Address the needs, strengths, and abilities of vulnerable populations.

Despite these achievements, self-sufficiency remains elusive for many. Only a third of adults in the TANF caseload are fully meeting work requirements. The Deficit Reduction Act (DRA) of 2005 (Public Law 109-171), which includes language reauthorizing TANF through 2011, challenges and encourages States to engage the remaining adult TANF recipients in work-related activities to move them up the economic ladder.

Addressing the needs of vulnerable children continues to be a priority of HHS. The most recent annual *HHS Child Maltreatment Report* (covering 2005) indicated that each year an estimated 899,000 children in the United States are victims of abuse or neglect. At the end of FY 2005, there were 513,000 children in foster care; 114,000 of these children were waiting to be adopted. Nearly 2 million children have a parent in a Federal or State correctional facility, a number that more than doubled over the 1990s.

Since 1996, the percentage of children born out of wedlock to teens has dropped but still remains unacceptably high. In addition, more adults are choosing to have children outside the protective bonds of marriage. Research suggests that, all other things being equal, children who grow up in healthy married, two-parent families do better on a host of outcomes; for instance, they are less likely to engage in criminal activity or abuse drugs and alcohol than those who do not. HHS's multicomponent *Healthy Marriage Initiative* works to help couples who have chosen marriage to gain access to services where they can acquire the skills and knowledge necessary to form and sustain healthy marriages. Making marriage education accessible and appropriate for families is a major component.

Children are not alone in their need for support. As the American population ages, enhanced efforts are needed to help the growing number of older persons remain active and healthy. An aging society means that the number of persons requiring long-term care services will increase. The availability of these services in the home and other community-based settings will be increasingly important if people are to 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.

Strategic Goal 3, *Human Services,* seeks to protect life, family, and human dignity by promoting the economic and social well-being of individuals, families, and communities; enhancing the safety and well-being of children, youth, and other vulnerable populations; and strengthening communities. The Administration for Children and Families (ACF), Administration on Aging (AoA), Center for Faith-Based and Community Initiatives (CFBCI), Office on Disability (OD), and Substance Abuse and Mental Health Services Administration (SAMHSA) are among the operating and staff divisions primarily responsible for achieving this strategic goal. In addition, HHS's Centers for Disease Control and Prevention (CDC), Health Resources and Services Administration (HRSA), and Office for Civil Rights (OCR) play important roles.

There are four broad objectives under *Human Services:*

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

Below is a description of each strategic objective, followed by a description of the key programs, services, and initiatives the Department is undertaking to accomplish those objectives. Key partners and collaborative efforts are included under each relevant objective. The performance indicators selected for this strategic goal are also presented with baselines and targets. These measures are organized by objective. Finally, this chapter discusses the major external factors that will influence HHS's ability to achieve these objectives, and how the Department is working to address those factors.

Strategic Objective 3.1

Promote the economic independence and social well-being of individuals and families across the lifespan.

HHS is committed to helping individuals and families achieve economic independence and social well-being, through individual efforts of ACF, AoA, OCR, OD, and SAMHSA, and in concert with the U.S. Departments of Justice and Labor, States, territories, tribes, and other interested stakeholders.

The focus is twofold. First, HHS will collaborate with States in moving disadvantaged families to work and economic self-sufficiency, using indicators to measure the movement of individuals from welfare to work, as well as increases in child support collection. Second, HHS supports interventions that help individuals and families who are disadvantaged improve their economic and social well-being across the lifespan; an indicator at the end of the chapter measures the success of services to individuals with developmental disabilities. The narrative below describes the efforts, initiatives, programs, and collaborations that the Department will implement in the next 5 years to address this strategic objective. Many of these are continuations and expansions of existing programs.

Work and Economic Self-Sufficiency

Temporary Assistance for Needy Families. *Temporary Assistance for Needy Families* (TANF), a block grant administered by ACF's Office of Family Assistance, provides temporary assistance and work opportunities to needy families by granting States the Federal funds and wide flexibility to develop and implement their own welfare programs. TANF provides funding annually to States, territories, and eligible tribes for the design of creative programs to help families transition from welfare to self-sufficiency. States have tremendous flexibility in determining how to use their TANF dollars to achieve program goals. Reauthorization of TANF in 2006 requires that States implement more meaningful work participation rate requirements in the coming years.

Child Care. To support working families, ACF provides States, territories, and tribes with direct child care assistance payments to low-income families when the parents work or participate in education or training. In collaboration with the U.S. Department of Education, ACF's Office of Head Start, and HRSA, ACF's Child Care Bureau promotes State flexibility in developing child care programs and policies that meet the needs of children and parents within each State; supports research and evaluation of innovative child care subsidy policies and Web-based access to reports, data, and other research-related information; and helps families to achieve and maintain self-sufficiency by improving access to affordable, high-quality child care.

Assets for Independence. The *Assets for Independence* (AFI) program uses asset-building strategies to assist low-income families in achieving economic independence. The program helps participants save earned income in special-purpose, matched savings accounts called *Individual Development Accounts* (IDAs). Every dollar in savings deposited by participants into an IDA is matched by the AFI program. The IDA mechanism promotes savings and enables participants to acquire a lasting asset after saving for a few years. AFI program families use their IDA savings, including the matching funds, to acquire a first home, capitalize a small business, or enroll in postsecondary education or training. In addition to helping participants with their IDA savings, all AFI programs provide basic training and supportive services related to family financial management. AFI continues to develop new partnerships to assist families. SCORE, a U.S. Small Business resource partner, helps AFI grantees saving for small business startups. Moreover, the 360 IDAs Initiative now helps increase the availability of IDAs to people with disabilities and their families.

Programs of the Administration for Native Americans. The *Administration for Native Americans* (ANA) in ACF promotes the goal of self-sufficiency by providing social and economic development opportunities. ANA programs offer training, as well as financial and technical assistance, and support a range of projects for eligible tribes and Native American organizations. ANA supports the creation of new jobs, development or expansion of business enterprises and social service initiatives, and formulation of environmental ordinances and training in the use and control of natural resources. Future grants will continue to support social and economic development strategies and healthy marriages to improve the well-being of children.

Child Support Enforcement. The *Child Support Enforcement* (CSE) program is a joint Federal, State, and local partnership that seeks to ensure financial and emotional support for children from both parents by locating noncustodial parents, establishing paternity, and establishing and enforcing child support orders. Child support services, as mandated in Title IV-D of the Social Security Act of 1935 (Public Law 74-271), as amended, are available for all families with a noncustodial parent, regardless of welfare status. Child support collections play an important role for families transitioning from welfare to self-sufficiency, particularly in light of time limits on receipt of cash assistance. By securing support from noncustodial parents on a consistent and continuing basis, families may avoid the need for public assistance, thus reducing government spending.

The CSE program continues to make strong gains in child support order and paternity establishment, as well as in collections of current and back support. The Deficit Reduction Act (DRA) of 2005 (Public Law 109-171) includes a series of provisions to strengthen and improve the program. Overall, DRA provisions will both strengthen existing collection and enforcement tools and allow States the option to provide additional support to families who need it most. These provisions include State options to direct more child support collections to children and families that ever received TANF; new efforts to increase collections such as expanding passport denial, mandatory review and adjustment of support orders, and improving medical support by requiring States to consider both parents' access to health insurance coverage when establishing child support orders; and an annual user fee for child support cases when enforcement efforts are successful for families who have never received TANF assistance.

Well-Being Across the Lifespan

Healthy Marriage and Responsible Fatherhood. The DRA provides funding for research and demonstrations that support healthy marriage. Approximately 125 Federal grants were awarded to States and communities to test new ways to promote and support healthy married-parent families. Grant funds will be used to test promising approaches to encourage healthy marriages and provide marriage education, marriage skills training, public advertising campaigns, high school education on the value of marriage, and marriage mentoring programs.

HHS supports several other healthy marriage activities and research, including *Building Strong Families*, *Supporting Healthy Marriages*, and the *Community Healthy Marriage Initiative.* The purpose of the *Building Strong Families* project is to evaluate healthy marriage services for romantically involved low-income, unwed parents around the time of the birth of a child. The purpose of *Supporting Healthy Marriages* is to inform program operators and policymakers of the most effective ways to help married parents to strengthen and maintain their marriages. The *Community Healthy Marriage Initiative* evaluates broad-based community-level coalitions that help couples who choose marriage for themselves to develop the skills and knowledge to form and sustain healthy marriages. In collaboration with the U.S. Department of State, HHS also promotes programs and policies at international organizations to strengthen families and marriages and to promote the preservation of human life and dignity.

The *Promoting Responsible Fatherhood Initiative* promotes responsible fatherhood by funding programs that support healthy marriage activities, enhance responsible parenting, and foster economic stability. The initiative will enable fathers to improve their relationships and reconnect with their children. It will help fathers overcome obstacles and barriers that often prevent them from being the most effective and nurturing parent possible. Although the primary goal of the initiative is to promote fatherhood in all of its various forms, an essential point is to encourage fatherhood within the context of marriage. Grant funds will be allocated to promote involved, committed, responsible fatherhood through counseling, mentoring, marriage education, enhancing relationship skills, parenting, and activities to foster economic stability.

Family Violence. ACF's *Family Violence Prevention and Services Program,* administered by the Family and Youth Services Bureau (FYSB), provides grants to States and tribes to prevent incidents of family violence, provide immediate shelter and related assistance for victims of family violence, and support prevention services for perpetrators. FYSB also supports programs that offer safe havens and access to services for victims of domestic violence, a national toll-free hotline to provide information and assistance to victims of domestic violence, maternity group home services, and runaway and homeless youth shelters.

Several collaborative efforts both within HHS and in partnership with other departments and stakeholders support this effort to prevent family violence. The *National Advisory Committee on Violence Against Women* is an advisory body cochaired by the Attorney General and the Secretary of HHS. National Advisory Committee members meet periodically to share their thoughts, ideas, and expertise and to submit recommendations on a variety of priority issues as the Federal Government develops its policies to address the crimes of domestic violence, sexual assault, dating violence, and stalking. The *Greenbook* initiative, a joint project of HHS and the U.S. Department of Justice, supported six demonstration projects, helping child welfare and domestic violence agencies and family courts work together more effectively to help families experiencing violence. Now that the funding cycle has been completed, HHS will partner with the U.S. Department of Justice and with the National Council of Juvenile and Family Court Judges to provide technical assistance and support to communities interested in implementing the *Greenbook*'s recommendations.

Support for Older Adults in Home and Community Settings. AoA's *Home and Community-Based Supportive Services* program provides an array of services to older adults and their caregivers, including access services such as transportation, case management, and information and referral; in-home services such as personal care, chore, and homemaker assistance; and community services such as adult day care, respite care, and disease prevention, health promotion, and physical fitness programs. Together, these services strive to help older adults maintain their independence and enable them to stay in their homes and communities for as long as possible, delaying the need for costly institutional care.

New Freedom Initiative and Olmstead Decision Response. The HHS Office on Disability (OD) was created in 2002 as an outcome of President Bush's *New Freedom Initiative.* The *New Freedom Initiative* commits the United States to a policy of community integration for individuals with disabilities. OD and OCR are involved in a variety of efforts to enhance the independence and quality of life of persons with disabilities, including those with long-term needs. OD, through the *New Freedom Initiative,* ensures a coordinated interagency and intergovernmental approach in support of community integration to tear down barriers on behalf of individuals with disabilities. In *Olmstead* v. *L.C.* (1999), the U.S. Supreme Court held that States unjustifiably segregating qualified persons with disabilities in institutions is a form of discrimination prohibited by Title II of the Americans with Disabilities Act of 1990 (Public Law 101-336). OCR has the authority to enforce the *Olmstead* decision, and has done so through hundreds of complaint investigations, voluntary compliance efforts, outreach initiatives, and technical assistance projects. Through these efforts, OCR ensures that, when appropriate, States provide individuals with disabilities access to services in the community. OCR will continue its *Olmstead*-related efforts, ensuring that individuals with disabilities return to or remain in their communities with adequate supports.

Low Income Home Energy Assistance Program. ACF's *Low Income Home Energy Assistance Program* (LIHEAP) will continue to provide home energy assistance through grants to States, tribes, and territories. Of the households receiving heating assistance, about one-third include a member 60 years or older; about half have at least one person with a disability; and about one-fifth include at least one child 5 years old or younger.[xxxii] For the past several years, almost 5 million households per year received LIHEAP assistance to help them through the winter months. The program also provides cooling assistance to about 400,000 households and weatherization assistance to about 90,000 more.

Strategic Objective 3.2

Protect the safety and foster the well-being of children and youth.

HHS is committed to protecting the safety and fostering the well-being of children and youth, through the combined efforts of ACF, SAMHSA, HRSA, and OD, and in partnership with other Federal departments, such as the U.S. Departments of Education and Justice, the Corporation for National and Community Service (CNCS), and other interested stakeholders.

Several of the Department's efforts relate to child maltreatment and safe and permanent living situations for children and youth, as represented by the performance measure at the end of this chapter, which focuses on the adoption rate for children involved with the child welfare system. Other programs and collaborations focus on child care and fostering school readiness, as measured by the percentage of Head Start programs that have a positive impact on verbal and mathematical abilities. Additional initiatives, including mentoring, abstinence education, youth development, and suicide prevention, foster positive behavior, as represented in the indicator focusing on the lack of interaction with law enforcement. Although many of these programs are not new, they will continue and will be strengthened during the period covered by this *Strategic Plan.*

Child Maltreatment

The *Child Abuse State Grant Program* plays a key role in the prevention of child abuse and neglect by funding postinvestigative services such as individual counseling, case management, and parent education. The *Child Welfare Services* program helps State child welfare agencies improve their services with the goal of keeping families together. Grants also are provided to develop and improve education and training programs and resources for child welfare professionals through the *Child Welfare Training* program and to prevent the abandonment of infants and young children exposed to HIV/AIDS and drugs through the *Abandoned Infants Assistance Program.* Over the next several years, funds

for new regional partnership grants will assist State and local agencies in building cooperative efforts addressing the range of issues presented by families whose substance abuse impairs parenting and places their children at risk. The *Independent Living Education and Training Vouchers* program provides up to $5,000 for costs associated with college or vocational training for youth ages 16 to 21 in foster care.

Two interagency workgroups focus on the issue of child abuse and neglect and provide settings within which Federal agencies coordinate and collaborate. The first, the *Federal Interagency Work Group on Child Abuse and Neglect,* led by the Office on Child Abuse and Neglect of ACF/Children's Bureau, engages ACF, CDC, HRSA, IHS, NIH, and SAMHSA, as well as the U.S. Departments of Agriculture, Defense, Interior, Justice, and Labor, State staff, and other partners, in its discussions on child abuse prevention, child welfare, and independent living support services. The group shares information, plans and implements joint activities, makes policy and programmatic recommendations, and works

toward establishing complementary agendas in the areas of training, research, legislation, information dissemination, and delivery of services as they relate to the prevention, intervention, and treatment of child abuse and neglect. The second, *NIH Neglect Consortium,* develops and supports research on child neglect, with support from ACF and the U.S. Department of Education. ACF/Children's Bureau is working with OD in supporting necessary research to understand the impact of child maltreatment on children and youth with disabilities residing in long-term care facilities and with families (including foster care).

Safety and Permanency

The Adoption and Safe Families Act of 1997 (Public Law 105-89) established that a child's health and safety must be of paramount concern in any efforts made by a State to preserve or reunify a child's family. ACF's *Foster Care, Adoption Assistance,* and *Independent Living* programs have demonstrated success in improving safety, permanency of living arrangements, and well-being of children. Working with the States, these programs minimize disruptions to the continuity of family and other relationships for children in foster care by decreasing the number of placement settings per year for a child in care. The programs also met goals to provide children in foster care with permanency and stability in their living situations by improving the timeliness of reunification, if possible, and promoting guardianship or adoption when reunification is not possible. In recent years, the Children's Bureau within ACF has pioneered a results-focused approach to monitoring Federal child welfare programs. The second round of these *Child and Family Service Reviews* began in 2007 and will hold States accountable for the safety, permanency, and well-being of children involved with child welfare authorities.

Additionally, the *Promoting Safe and Stable Families* (PSSF) program, a capped entitlement program authorized through the Promoting Safe and Stable Families Act of 1997 (Public Law 105-89), assists States in coordinating services related to child abuse prevention and family preservation. These services

include community-based family support, family preservation, time-limited reunification services, and adoption promotion and support services. Inspired by research showing that regular caseworker visits are related to the achievement of important child and family outcomes for children in foster care, new funding within the PSSF program provides resources to States to help them ensure that caseworkers visit children monthly.

Through the *Adoption Incentives* program, States will be able to earn bonus payments by increasing the number of adoptions of children in foster care over previous years. The *Adoption Opportunities* program supports grants that facilitate the elimination of barriers to adoption, and the adoption awareness programs support adoption efforts, including adoption of children with special needs, through training and a public awareness campaign. Adoption incentives added in the 2003 reauthorization of the *Adoption Incentive Payments Program* focus on adoptions of children age 9 and older who face particularly long waits for adoptive homes.

Early Care and Education

ACF's *Head Start* and *Early Head Start* programs are comprehensive child development programs that serve children from birth to age 5, pregnant women, and their families. Head Start is designed to foster healthy development and school readiness in low-income children. *Head Start* programs help ensure that children are ready to succeed at school by supporting social and cognitive development. *Head Start* programs provide comprehensive child development services, including educational, health, nutritional, and social services, primarily to low-income families. They also engage parents in their child's preschool experience by helping them achieve their own educational and literacy goals as well as employment goals, supporting parents' role in their children's learning, and emphasizing the direct involvement of parents in the administration of local *Head Start* programs. *Early Head Start* has a triple mission. It promotes healthy prenatal outcomes, enhances the development of infants and toddlers, and promotes healthy family functioning. HHS will continue to explore how to maximize the use of technology to disseminate information and research in ways that will improve programs and performance. HHS will investigate ways that Head Start and child care can collaborate with other State and local partners, such as State prekindergarten programs, to ensure that children enter school ready to succeed.

Several collaborative efforts between HHS and the U.S. Department of Education support early childhood programs and research. The *Good Start, Grow Smart* interagency workgroup, with HHS representatives from ACF/Office of Head Start, ACF/Child Care Bureau, NIH, and ASPE, focuses on enhancing early childhood programs and fosters better collaboration among agencies serving young children at risk. The *Interagency School Readiness Initiative* engages the same operating and staff divisions from HHS and the U.S. Department of Education to focus on enhancing early childhood research. Another interagency collaboration, the *Early Childhood Workgroup on English Language Learners,* involves ACF and ASPE in developing strategies for coordination of early childhood programs aimed at English Language Learners.

Mentoring

Research indicates that children with parents who are incarcerated are seven times more likely than the general population to become incarcerated themselves and are more likely to display a variety of behavioral, emotional, health, and educational problems. Through ACF's Family and Youth Services Bureau (FYSB), HHS supports the *Mentoring Children of Prisoners* program, through which public and private organizations establish or expand projects that provide one-on-one mentoring for children of parents who are incarcerated and those recently released from prison.

OD promotes physical fitness for children and youth with disabilities in conjunction with the President's HealthierUS Initiative and the President's Council on Physical Fitness and Sports awards system, through its *"I Can Do It, You Can Do It"* mentoring program. This

program features one-on-one mentoring for children and youth with disabilities across the Nation to enhance their physical fitness, with the goal of serving 6 million children with disabilities.

HHS also participates on the recently formed Federal Mentoring Council, an offshoot of the *Coordinating Council on Juvenile Justice and Delinquency Prevention* (see the section, *Collaborative Efforts to Support Youth*, for more information on this Council). Convened and staffed by the CNCS, the Council seeks to improve coordination and better leverage resources among all the mentoring programs that exist in the Federal Government. The Council includes representatives from the U.S. Departments of Defense, Education, Interior, Justice, Labor, and many others. The Council works to identify key ways in which the Federal Government can advance the goal of involving 3 million new mentors by 2010, and then act on those findings.

Abstinence Education

ACF administers two abstinence education programs—the *Community-Based Abstinence Education* program and the *State Abstinence Education* program. ACF's abstinence education programs provide grants to community-based organizations, including faith-based organizations, as well as to States, to develop and implement abstinence programs. The *Community-Based Abstinence Education* program focuses on adolescents, ages 12 through 18, and targets the prevention of teenage pregnancy and premarital sexual activity. The *Community-Based Abstinence Education* program also supports a national public awareness campaign designed to help parents communicate with their children about health risks of early sexual activity. The *State Abstinence Education* program enables States to create or augment existing abstinence education programs and, where appropriate, provide mentoring, counseling, and adult supervision to promote abstinence from sexual activity, with a focus on those groups most likely to bear children out of wedlock. ACF expects that all grantees will present medically accurate information. ACF is requiring *Community Based Abstinence Education* grantees to certify that curricula are medically accurate and is conducting reviews for medical accuracy as part of the grant award process.

Within OPHS, the *Adolescent Family Life Program* (AFL) also supports abstinence education activities. Through Title XX of the Public Health Service Act (42 U.S.C., 300z et seq.), AFL authorizes two types of demonstration projects: (1) care projects to develop, implement, and evaluate innovative, comprehensive, and integrated approaches to the delivery of health care, education, and social services for pregnant and parenting adolescents and their families; and (2) prevention projects to develop, implement, and evaluate program interventions to promote abstinence from sexual activity among preadolescents and adolescents. AFL also places a strong emphasis on ensuring that educational materials are medically accurate.

OPHS, through an interagency agreement with ACF, has launched an initiative that focuses on the importance of parental communication. The *Parents Speak Up National Campaign* (PSUNC) is an educational campaign aimed at encouraging parents to talk with their children early and often about abstinence. This interactive campaign will include radio, print, and television advertisements to raise awareness. All PSUNC products direct parents to the 4Parents.gov Web site for further information and skills on talking early and often with their children about sex and abstinence. 4Parents.gov provides concise, helpful health information regarding the importance of parent-teen communication. The Web site also provides specific information on sexually transmitted diseases and teen pregnancy, benefits of abstinence from sexual involvement, drugs and alcohol, development of healthy teen relationships, and preparation for future marriage and family.

Collaborative Efforts for Youth

Positive Youth Development is an approach to youth programming based on the understanding that all young people need support, guidance, and opportunities during adolescence, a time of rapid growth and change. FYSB's *Positive Youth Development State and Local Collaboration Demonstration* grants will continue to develop and support innovative youth development strategies.

Together with nine other Federal agencies, HHS also supports the First Lady's *Helping America's Youth* initiative, which focuses on the importance of connecting caring adults with youth in order to help youth make better choices that lead to healthier, more successful lives. The *Community Guide to Helping America's Youth* helps communities build partnerships and assess their needs and resources. It also offers information about evidence-based youth program designs that could be replicated in their community. In the coming years, the *Community Guide* will continue to be enhanced so that it serves the needs of local youth-focused partnerships.

Representatives from several operating and staff divisions within HHS also participate with nine other Federal agencies and eight practitioner members on the *Coordinating Council on Juvenile Justice and Delinquency Prevention.* The Council's primary functions are to coordinate Federal juvenile delinquency prevention programs, Federal programs and activities that detain or care for unaccompanied juveniles, and Federal programs relating to missing and exploited children. The Council works to implement several of the recommendations from the 2003 report of the White House Task Force on Disadvantaged Youth. In the coming years, the Council will conduct an inventory of comprehensive community initiatives and will investigate how to support collaboration among Federal, State, and local partners, to determine how best to invest Federal resources to serve youth.

HHS will continue to participate in the Federal Government delegations that attend the meetings of the *Executive Board of the United Nations Children's Fund.* The Department also will promote programs and policies at international organizations to protect the interests and well-being of children and their families.

Strategic Objective 3.3

Encourage the development of strong, healthy, and supportive communities.

HHS is committed to encouraging the development of strong, healthy, and supportive communities. ACF, CDC, OD, OPHS, and SAMHSA fund comprehensive community initiatives to help distressed communities address the most intractable problems. The Center for Faith-Based and Community Initiatives (CFBCI) works to develop the capacity of faith-based and community-based organizations to respond to community needs. In the performance indicator section at the end of this chapter, the *Strategic Plan* uses family cohesiveness as a proxy for the strength of communities.

Below is a sampling of the Department's efforts related to faith-based and community initiatives, capacity building, and comprehensive community initiatives.

Faith-Based and Community Initiatives

HHS has made great strides in improving current faith-based and community partnerships, providing opportunities for new partnerships with faith-based and community organizations, and removing existing barriers to the inclusion of these groups in HHS programs. Through the HHS CFBCI, technical assistance has been provided throughout the country to increase the capacity of faith-based and community organizations working with vulnerable and needy populations. HHS has reached out and collaborated with religious and neighborhood organizations that for decades have been bringing solutions to bear on some of the Nation's most intractable problems. CFBCI works with operating and staff divisions across the Department to eliminate barriers to the participation of faith-based and other community organizations; these barriers include regulations, policies, and procedures. CFBCI also works with operating and staff divisions to propose the development of innovative pilot and demonstration programs. Finally, HHS staff have received training to understand how to reach out and partner with these organizations more effectively.

Capacity-Building Efforts

The Compassion Capital Fund advances the efforts of community and charitable organizations, including faith-based organizations, to increase their effectiveness and enhance their ability to provide social services where needed. Grants support intermediary organizations that provide training and technical assistance to grassroots organizations in accessing funding sources, administering programs, expanding services, and replicating promising approaches. In addition, targeted capacity-building minigrants help grassroots organizations more effectively deliver services to the most vulnerable populations including youth at risk, persons experiencing homelessness, families transitioning from welfare to work, and prisoners reentering the community.

Comprehensive Community Initiatives

SAMHSA funds several comprehensive community mental health services grants for children and youth with serious emotional disturbances and their families. Grants are used to implement a "systems of care" approach to services, based on the recognition that the needs of children with serious mental health challenges can best be met within their home, school, and community, and that families and youth should be the driving force in the transformation of their own care. The grants will be used to provide a full array of mental health and support services organized on an individualized basis into a coordinated network in order to meet the unique clinical and functional needs of each child and family.

OD is coordinating an interagency and interdepartmental 2-year seamless program, the *Young Adult Program.* This program promotes integrated support systems spanning education, health, assistive technology, employment, transportation, and housing for young adults 14 to 30 years with disabilities in six demonstration States through the National Governors Association and is documenting outcomes through a process and impact evaluation.

Strategic Objective 3.4

Address the needs, strengths, and abilities of vulnerable populations.

HHS is committed to addressing the needs, strengths, and abilities of vulnerable populations, including people with disabilities, American Indians and Alaska Natives, refugees and other entrants, victims of human trafficking, persons experiencing homelessness, and people affected by natural or manmade disasters. ACF, AoA, CDC, OCR, OD, and SAMHSA have developed programs and initiatives tailored for these particularly vulnerable populations. The two selected performance indicators at the end of this chapter that focus on this issue look at services provided to homebound older people and newly arrived refugees. Below are a few of the Department's efforts.

People With Disabilities

A number of interagency collaborations have developed to support the economic independence and social well-being of people with physical, sensory, behavioral, cognitive, and developmental disabilities. One is the joint planning effort between AoA, CMS, HRSA, IHS, NIH, OCR, OD, SAMHSA, and non-Federal organizations, including State developmental disability agencies, long-term care providers, tribal governments, State and local agencies on aging, and State and local Medicaid agencies. These agencies and organizations work to increase the independence and quality of life of persons with disabilities, including those with long-term care needs.

Another collaboration, the *Committee for Employees with Disabilities,* with representation from 14 HHS operating and staff divisions, represents the issues and needs of the Department's employees with disabilities; provides proactive advice, guidance, and recommendations to the Secretary in planning, implementing, monitoring, and evaluating the Department's affirmative action program on employment of individuals with disabilities; and serves as a focal point for the concerns of employees with disabilities on matters affecting their employment to help resolve Departmentwide problems in this area.

American Indians and Alaska Natives

The Administration for Native Americans (ANA) promotes economic and social self-sufficiency for American Indians, Alaska Natives, Native Hawaiians, and other Native Pacific Islanders by providing funding for community-based short-term projects through three competitive discretionary grant programs to eligible tribes and nonprofit Native American organizations. The three program areas are *Social and Economic Development Strategies for Native Americans; Native Language Preservation and Maintenance;* and *Environmental Regulatory Enhancement,* which focuses on building the capacity to identify, plan, and develop environmental programs consistent with Native culture.

Coordination with HHS is fostered by the *Intradepartmental Council on Native American Affairs,* cochaired by the Director of IHS and the Commissioner for the ANA. The purposes of the Council are to develop and promote policies to provide greater access and quality services for American Indians and Alaska Natives; identify and develop legislative, administrative, and regulatory proposals that promote effective policy; develop a comprehensive strategy that promotes self-sufficiency and self-determination; promote the tribal/Federal Government-to-government relationships on a Departmentwide basis; and ensure that the HHS policy on tribal consultation is implemented by all HHS divisions and offices. Within HHS, all operating divisions and many staff divisions are engaged in this important collaborative effort.

People Affected by Disasters

For victims of natural disasters, immediate priorities are access to water, food, shelter, medical care, and security. As individuals attempt to recover and rebuild their lives, they must also contend with stressors on their mental health, which can linger for weeks or months. Almost everyone who lives through disastrous events experiences feelings of sadness and depression. Depending on the individual, these feelings can vary in intensity and duration. This is true not only for the residents of the cities and towns devastated by natural disasters, but also for the thousands of rescue workers, emergency medical personnel, and disaster recovery experts engaged in search-and-rescue operations.

SAMHSA is focused on providing resources to aid in the recovery process, to assist both the people in areas damaged by natural disasters and the workers who are taking care of them. SAMHSA's *Disaster Technical Assistance Center* helps ensure that our Nation is prepared and able to respond rapidly when events increase the need for trauma-related mental health and substance abuse services.

AoA offers a comprehensive set of technical assistance materials to help prepare and plan for the management of major emergencies or disaster events. AoA has developed a technical assistance guide, which includes many tools to assist those with the responsibility for the safety and continued independence of the Nation's older population. The guide helps State agencies and local providers work through the intricate planning and collaborative efforts needed in an emergency. Using this guide, emergency teams will be ready to begin work immediately should a disaster or emergency occur.

The Office on Disability, in conjunction with ASPR and ACF's Administration on Developmental Disabilities, has implemented and monitored the use of a disability-based toolkit, shelter assessment tool, and public health staff training modules. Together with the HIPAA Privacy decision tool for emergency preparedness planning, created by OCR, these resources ensure that the needs of persons with disabilities are understood by first responders and other emergency response providers at the Federal, State, and local levels during all emergency situations.

Interruptions in child care services during an influenza pandemic may cause conflicts for working parents that could result in high absenteeism in workplaces. Some of that absenteeism could be expected to affect personnel and workplaces that are critical to the emergency response system. A checklist created by CDC will help child care and preschool programs prepare for the effects of a flu pandemic and will help them protect the health of their staff and the children and families they serve. Many of these steps can also help in other types of emergencies.

For more information on this topic, see *In the Spotlight: Emergency Preparedness, Prevention, and Response.*

Refugees and Other Entrants

The Office of Refugee Resettlement (ORR) in ACF offers a variety of services to support refugees, migrants, and other entrants, including victims of human trafficking. Assistance to refugees includes transitional cash assistance, health benefits, and a wide variety of social services, provided through ORR grants. The primary focus is employment services such as skills training, job development, orientation to the workplace, and job counseling. The priority is to find employment early after arrival, because it not only leads to early economic self-sufficiency for the family, but also adds greatly to the integrity of families who seek to establish themselves in a new country and provide for their own needs.

In addition to economic assistance to adults, ORR supports the *Unaccompanied Refugee Minors* program, which delivers child welfare services in a culturally sensitive manner. Specifically, the program assists refugee and entrant youth younger than 18 who are without a responsible adult in developing appropriate skills to enter adulthood and to achieve economic and social self-sufficiency. The *Unaccompanied Alien Children* program provides a safe and appropriate environment for minors during the interim period between the minor's transfer into a shelter care facility and the minor's release from custody by ORR or removal from the United States.

Victims of Human Trafficking

The Trafficking Victims Protection Act of 2000 (Public Law 106-386), as amended, designates HHS as the Federal Agency responsible for helping victims of human trafficking become eligible to receive benefits and services so that they may rebuild their lives safely in this country. As part of this effort, HHS has initiated the *Rescue & Restore Victims of Human Trafficking* campaign to help identify and assist victims of human trafficking in the United States. The intent of the campaign is to increase the number of identified trafficking victims and to help those victims receive the benefits and services needed to live safely in the United States. By initially educating health care providers, social service organizations, and the law enforcement

community about the issue of human trafficking, HHS will encourage these intermediaries to look beneath the surface by recognizing clues and asking the right questions because they might be the only outsiders with the chance to reach out and help victims. A critical component of the campaign is the creation of the *Trafficking Information and Referral Hotline,* which connects victims of trafficking to nongovernmental organizations that can help victims in their local areas. The hotline helps intermediaries determine whether they have encountered a victim of human trafficking, helps connect victims to resources, and coordinates with local social service organizations to protect and serve victims of trafficking.

People Experiencing Homelessness

The delivery of treatment and services to persons experiencing homelessness is included in the activities of the Department, both in 5 programs specifically targeted to such individuals and in 12 nontargeted, or mainstream, service delivery programs. To improve the response of HHS programs to homelessness, a crosscutting Departmental workgroup, the *Secretary's Work Group on Ending Chronic Homelessness,* meets quarterly to develop, lead, and coordinate a comprehensive Departmental approach to addressing homelessness. The group also supports the Secretary in his role as a statutory member of the *United States Interagency Council on Homelessness* (USICH). The USICH coordinates the Federal response to homelessness across 20 Federal departments and agencies and provides leadership for activities designed to assist families and individuals who are experiencing homelessness with the goal of preventing and ending it in the Nation. The Secretary chairs the USICH in 2007. HHS coordinates extensively with its Federal partners in developing research and program initiatives that will improve access to housing and treatment resources and contribute to ending homelessness.

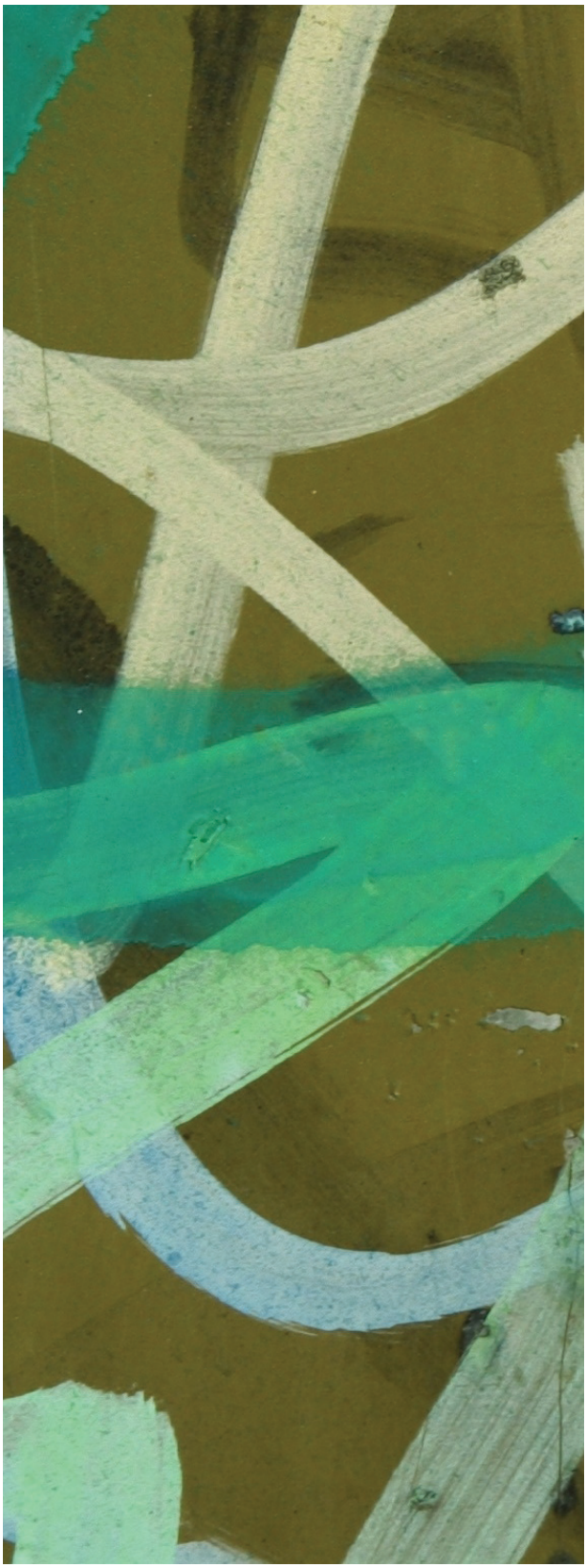
SAMHSA's *Projects for Assistance in Transition from Homelessness* (PATH) program is a formula grant program that funds the 50 States, District of Columbia, Puerto Rico, and 4 territories to support service delivery to individuals with serious mental illnesses, as well as individuals with co-occurring substance use disorders or other disabilities, who are homeless or at risk of becoming homeless. SAMHSA provides technical assistance to States and local providers funded by the PATH program, including onsite consultation, collection of annual reporting data, development of an annual report to the U.S. Congress, holding of biannual meetings of PATH program contacts, and identification and dissemination of best practices from the program.

HRSA's program, *Health Care for the Homeless* centers, provides individuals and families experiencing homelessness with access to comprehensive preventive and primary care services, including oral health, mental health, and substance abuse services. These services are provided in a variety of settings that promote access, including homeless shelters and mobile clinics. The program currently serves as the source of care for approximately 600,000 people per year.

Performance Indicators

		Most Recent Result	FY 2012 Target
Strategic Objective 3.1 Promote the economic independence and social well-being of individuals and families across the lifespan.			
3.1.1	Increase the percentage of adult TANF recipients who become newly employed.	34.3%	39%
3.1.2	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.	11.27%	11.34%
3.1.3	Increase the child support collection rate for current support orders.	60%	63%
Strategic Objective 3.2 Protect the safety and foster the well-being of children and youth.			
3.2.1	Increase the adoption rate for children involved in the Child Welfare System.	10.06%	10.40%
3.2.2	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.	a) 52%; and b) 84.6%.	a) 66%; and b) 86%.
3.2.3	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.	69.3%	70%
Strategic Objective 3.3 Encourage the development of strong, healthy, and supportive communities.			
3.3.1	Increase the number of children living in married couple households as a percentage of all children living in households.	69%	72%
Strategic Objective 3.4 Address the needs, strengths, and abilities of vulnerable populations.			
3.4.1	Increase the number of older persons with severe disabilities who receive home-delivered meals.	313,362	500,000
3.4.2	Increase the percentage of refugees entering employment through refugee employment services funded by ACF.	53.49%	60%

Note: Additional information about performance indicators is included in Appendix B.



Meeting External Challenges

Within the human service goal, changes in economic conditions, specifically downturns, have been shown to be the most influential external factor influencing how successful HHS's strategies are in accomplishing its stated objectives.

Historically, when negative economic conditions occur, welfare recipients, low-income people, and persons with disabilities are more vulnerable to unemployment; and fewer local resources and safety nets exist for these populations. Decreases in State and local revenue could result in a reduction in funding for home and community-based placements for individuals with disabilities. Family stress is greater as economic situations deteriorate, leading to increased potential for violence and family breakup. Noncustodial parents may lose jobs or income resulting in fluctuations in income support ability.

To mitigate these effects, HHS works at the State level to enhance States' capacity to coordinate a broad range of services, conducts research, provides technical assistance, and identifies best practices that focus on elimination of barriers for the hard-to-employ and cost-effective service delivery. Additionally, HHS can assist community action agencies, community development corporations, and other community groups in leveraging Federal, State, local, and philanthropic resources to strengthen neighborhoods; build social capital by developing community leadership and strengthening community-based organizations; and support asset development projects for residents of distressed communities. On the individual level, HHS provides information and support for consumers and their caregivers and ensures individuals and families are connected to safety net programs for which they are eligible through outreach and referral. HHS also provides support for child care services, working to connect families with the most appropriate child care setting (also called parental choice) and helping families moving into work to remain connected to other safety net programs for which they are eligible. Child support enforcement activities can also be coordinated with opportunities for job training and supported work activities.

Efforts to improve the health and well-being of Americans over the next 5 years will be shaped by important changes in demographics. Our Nation is growing older and becoming more racially and ethnically diverse.

Aging Population

More Americans are living longer, and the proportion of the Nation's population that is age 65 or older is growing rapidly. A baby born in 2006 can expect to live to age 78. This age expectancy represents a gain of more than 10 years since 1965, when the Older Americans Act of 1965 (Public Law 89-73) first authorized Medicare and Medicaid. From 1950 to 2006, the total resident population of the United States doubled from 150 million to more than 300 million. During this same period, the population 65 years of age and over grew twice as rapidly, increasing from 12 to 36 million. According to projections from the U.S. Census Bureau, after the first Baby Boomers turn 65 in 2011, the number of older people will substantially increase. In 2030, the older population is anticipated to be twice as large as in 2000, and will represent nearly 20 percent of the total U.S. population.[xxxiii]

The aging of the population has important implications for health care, public health, and human service systems. As the older fraction of the population increases, more services will be required for the treatment and management of chronic and acute health conditions and disabilities. The average 75 year old has three chronic conditions and uses five different prescription drugs.[xxxiv] Today's health care workforce lacks much of the training required to provide appropriate care to today's older adults and is thus unprepared for the projected increase in the number of older Americans over the next 20 years. Equally important, the health care workforce is older than in the past.

Across the country, long-term care providers are facing a shortage of qualified and committed direct care workers—those certified nursing assistants, home health aides, and personal care workers who provide hands-on care to millions of older adults and individuals with disabilities. Over the next 10 years, the country will need an estimated 874,000 additional direct care workers to meet growing demand. At the same time, the supply of workers traditionally relied upon to fill these positions—middle-aged women— will fall by about half by 2030.[xxxv]

Older Americans also have behavioral health and human service needs. Some older adults experience late onset of mental and addictive illnesses; others have experienced them throughout their lives. Older adults may experience depression and anxiety as they face physical decline, death of family members and other loved ones, and increased limitations in normal daily activities. In lieu of seeking treatment, some older adults—as with other populations—may "self-medicate" with alcohol. Further, older adults may misuse prescription or over-the-counter medications, often inadvertently.

The science of aging indicates that chronic disease and disability are not inevitable. As a result, health promotion and disease prevention activities and programs are an increasing priority for older adults, their families, and the health care system.

Racial/Ethnic Diversity

Diversity has long been a characteristic of the Nation's population, but the racial and ethnic composition has changed over time. In recent decades, the percent of the population that is of Hispanic or Asian origin has more than doubled. In 2000, 19 percent of the population identified themselves as Black or African-American, Asian, American Indian or Alaska Native, Native Hawaiian or Other Pacific Islander, or of more than one race; 12.6 percent of the total U.S. population identified themselves as of Hispanic origin. The U.S. Census Bureau projects that by 2010, 20.7 percent of the total U.S. population will identify themselves as Black or African-American, Asian, American Indian or Alaska Native, Native Hawaiian or Other Pacific Islander, or of more than one race; and 15.5 percent will identify themselves as of Hispanic origin.[xxxvi]

The U.S. Census Bureau also reports that nearly one in five people, or 47 million U.S. residents age 5 and older, spoke a language other than English at home in 2000—an increase of 15 million people since 1990. According to the report, Spanish speakers increased from 17.3 million in 1990 to 28.1 million in 2000, a 62 percent rise. Only 55 percent of the people who speak a language other than English at home report they speak English "very well."[xxxvii]

These changes in the racial and ethnic composition of the population have important consequences for the Nation's health because many of the measures of disease and disability differ significantly by race and ethnicity. These shifts in the racial and ethnic makeup of the United States require health professionals and organizations to achieve cultural competence and to ensure that they utilize appropriate and tailored approaches in working with these population groups.

Chapter 5

Strategic Goal 4:

Scientific Research and Development

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

Disease and injury are constant threats to humankind and are never static. Diseases, such as HIV/AIDS, SARS, pandemic influenza, obesity, and many other conditions can emerge at any time. Twenty years ago, the impact of Alzheimer's disease was not fully appreciated, and its causes were not known. Bioterrorism did not figure prominently in the scientific research and development agenda in 2001, but is now a top priority for numerous HHS divisions, including FDA, NIH, and CDC.

STRATEGIC GOAL 4:
SCIENTIFIC RESEARCH AND DEVELOPMENT

Strategic Objective 4.1:
Strengthen the pool of qualified health and behavioral science researchers.

Strategic Objective 4.2:
Increase basic scientific knowledge to improve human health and human development.

Strategic Objective 4.3:
Conduct and oversee applied research to improve health and well-being.

Strategic Objective 4.4:
Communicate and transfer research results into clinical, public health, and human service practice.

As a result of success in preventing and treating acute and short- term conditions such as heart attacks, stroke, cancer, and many infectious diseases, people are living longer. The increasingly older population faces the new challenge of multiple chronic conditions that now consume about 75 percent of health care expenditures. The Nation is in a continuous race against the overwhelming 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 practice efforts.

The 21st century is an era of great scientific opportunity. Advances in the understanding of basic human biology allowed NIH to sequence the human genome by 2003, 2 years ahead of schedule, and to complete the haplotype map, showing the variation between individual humans, in October 2005. New advances enable new treatments that could lead to the transformation of medical treatment in this century. The hope is to usher in an era in which medicine will begin to be predictive, personalized, and preemptive. Personalized medicine has the potential to transform health care through earlier diagnosis, more effective prevention and treatment of disease, and avoidance of drug side effects.

Basic science is the foundation for improved health and human services. However, 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 and applied research to practice is a significant emphasis of HHS's scientific research and development enterprise.

Strategic Goal 4, *Scientific Research and Development,* seeks to connect this path from basic research to practice through four broad objectives:

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

A number of HHS operating and staff divisions, including the Agency for Healthcare Research and Quality (AHRQ), Centers for Disease Control and Prevention (CDC), Food and Drug Administration (FDA) and, most significantly, the National Institutes of Health (NIH), sustain and contribute to a full spectrum of scientific research and development activities.

NIH supports and conducts investigations across the full range of the health research continuum, including basic research, which may be disease oriented or related to the development and application of breakthrough technologies; observational and population-based research; behavioral research; prevention research; health services research; translational research[15]; and clinical research,[16] as well as research on new treatments or prevention strategies.

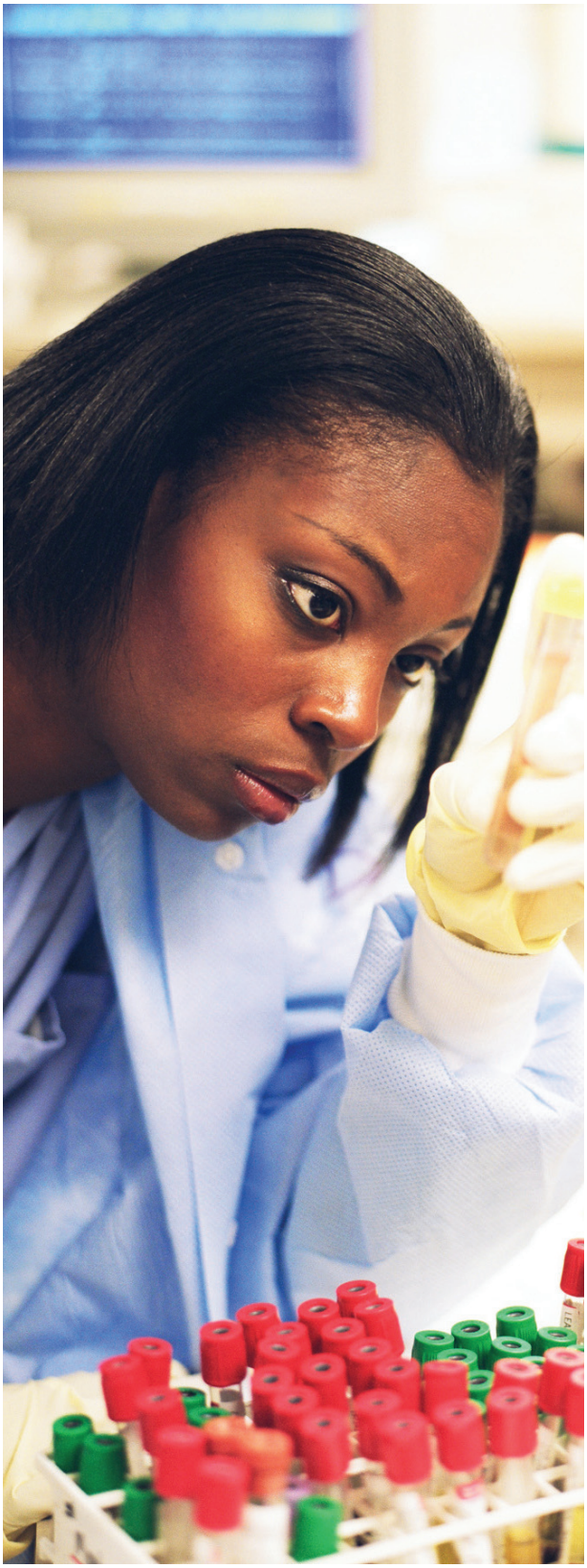
FDA supports the research and development goal as a scientific regulatory agency. It is responsible for protecting the public health by assuring the safety, efficacy, and security of human and veterinary drugs, biological products, medical devices, and the Nation's food supply. FDA also ensures the safety of cosmetics and products that emit radiation. FDA advances the public health agenda by helping to speed innovations to market that make medicines more effective and to provide the public accurate, science-based information needed regarding medicines and foods to improve its health. FDA plays a significant role in addressing the Nation's counterterrorism capability and in ensuring the security of the food supply. FDA conducts applied and translational research that enables it to develop regulatory standards and risk assessment criteria to reach sound, science-based public health decisions on regulated products. All of these activities are conducted in collaboration with numerous public and private partners, including academic research institutions; nonprofit foundations; and vaccine, pharmaceutical, and medical device industries.

15 Translational research involves the application of laboratory findings to clinical interventions.

16 Clinical research includes research to understand both normal health and disease states.

CDC focuses primarily on epidemiological and public health practice research. AHRQ has established a broad base of scientific research and promotes evidence-based improvements in clinical practice and in the organization, financing, and delivery of health care services.

Below is a description of each strategic objective, followed by a description of the key programs, services, and initiatives the Department is undertaking to accomplish those objectives. Although HHS supports a wide array of research and development activities, these represent the major areas of the emphasis for the Department over the next 5 years. Key partners and collaborative efforts are included under each relevant objective. The performance indicators selected for this strategic goal are also presented with baselines and targets. These measures are organized by objective. Finally, this chapter discusses the major external factors that will influence HHS's ability to achieve these objectives, and how the Department is working to mitigate those factors.



Strategic Objective 4.1

Strengthen the pool of qualified health and behavioral science researchers.

The average age of first-time (new) principal investigators of research funded by NIH has risen to 42 years for Ph.D. degree holders and 44 years for M.D. and M.D./Ph.D. holders. This trend must be curtailed in order to capture the creativity and innovation of new independent investigators in their early career stages to address the Nation's health-related research needs.

The National Research Council of the National Academies of Science issued two reports in 2005 about research training and career development with calls for immediate action. NIH will continue to respond to this need to assist and mentor creative young researchers through existing programs. NIH is also developing new initiatives to complement existing efforts to strengthen the pool of qualified health and behavioral science researchers.

NIH will continue to support the *Ruth L. Krischstein National Research Service Award Research Training Grants and Fellowships Program.* This program provides grant and fellowship funding for individual investigators with or working on a research-related or health-profession doctorate degree. Individual awards promote diversity in health-related research fields across NIH. HHS will use the retention rate of these trainees and fellows as an indicator of its success in improving the pool of qualified researchers. NIH will also support the *Pathway to Independence Award Program.* This program is an innovative and new opportunity for promising postdoctoral scientists to receive both mentored and independent research support from the same award. NIH will also continue to work with IHS to support the *Native American Research Centers for Health* to increase the number of AI/AN researchers.

Strategic Objective 4.2

Increase basic scientific knowledge to improve human health and human development.

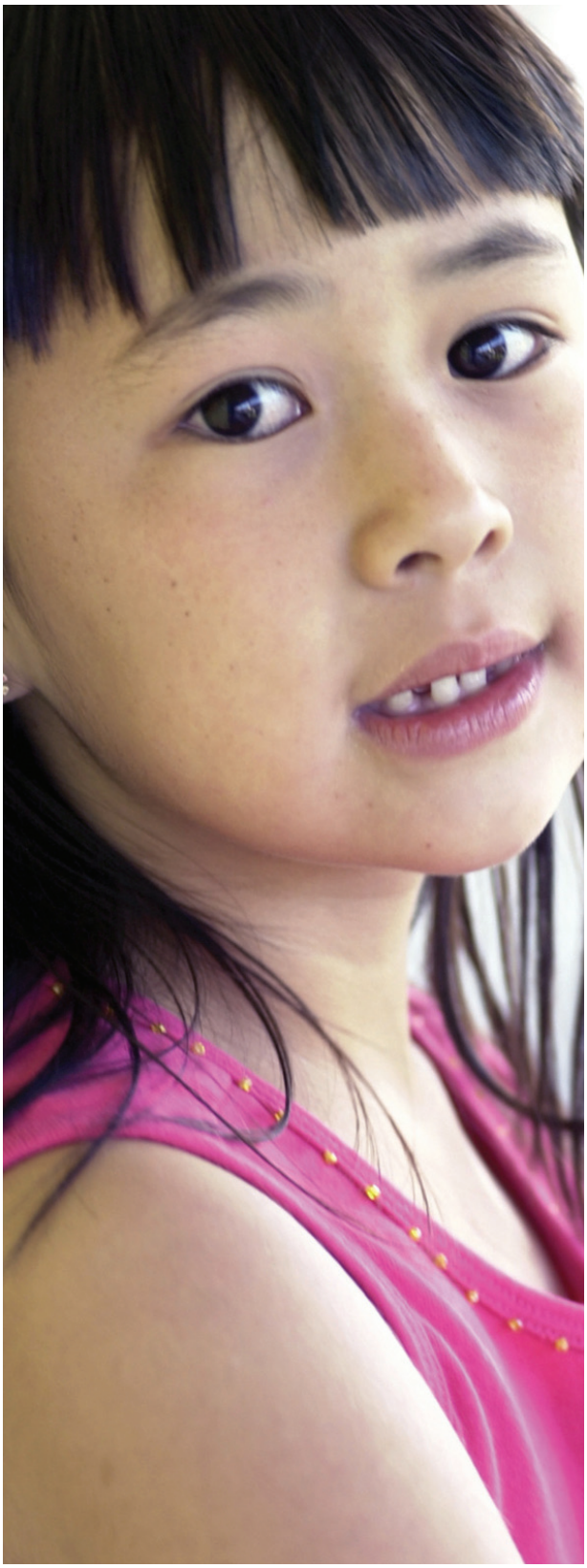
Basic research contributes significantly to personalized health care and to increasing understanding of human makeup and biological processes. Current and future basic research projects in HHS focus on those areas with the greatest potential for reduction in excess morbidity and mortality, including brain function, human development, asthma and other respiratory diseases, cancers, dementia, influenza strain mapping, and antimicrobial resistance. The performance indicators for this strategic objective highlight research efforts related to major diseases, including cardiovascular disease and Alzheimer's, and imaging tools for the early detection of diseases, including cancer.

Brain Research

The rising public health impact of disorders of the nervous system makes neuroscience one of the most important scientific frontiers for biomedical and behavioral research in this century. Discoveries in the areas of pain, alcoholism, drug abuse, autism, schizophrenia, depression, and other mental disorders are increasing dramatically. NIH will build on these discoveries by continuing to support research to better understand the processes of the brain, including improving imaging technologies to be able to visualize brain processes as they happen. The increased understanding of the nerve circuits will pave the way for improved diagnosis and treatment of common diseases such as depression, stroke, and epilepsy and reduced burden on the Nation in terms of both suffering and health care costs. NIH will also support the *Autism Phenome Project,* which will identify various clinical characteristics and subtypes of autism to facilitate research on genetic and other potential causes of autism and to guide applied research related to treatment approaches.

Alzheimer's Disease

Alzheimer's disease, the most common cause of dementia among people older than 65, is one of the most serious threats to the Nation's health and economic well-being. Currently, 4.5 million Americans are affected by the disease; that number is expected to almost triple by 2050. Those suffering from Alzheimer's disease advance inexorably, from early, mild forgetfulness to a severe loss of mental function and inability for self-care. Existing research suggests that Alzheimer's disease pathology begins to develop in the brain long before clinical symptoms yield a diagnosis. The ability to make an accurate early diagnosis of Alzheimer's disease would allow targeted intervention before cognitive loss becomes significant. NIH is searching for valid, easily attainable biological markers that could help identify biological markers for early disease. For example, NIH will support research to examine one promising approach that involves using coated gold nanoparticles as bioprobes to measure



the concentrations of substances that correlate with Alzheimer's disease. NIH will also continue to support the *Alzheimer's Disease Neuroimaging Initiative*. The 5-year, 50-site project represents the most comprehensive effort to date to develop neuroimaging and other biomarkers for the changes associated with mild cognitive impairments and Alzheimer's disease. The ongoing *Genetics Initiative* will also support the development of resources necessary for identifying late-onset risk factor genes, associated environmental factors such as physical activity and diet, and their interactions.

Human Development

NIH is committed to funding a diverse portfolio of basic and translational research that addresses the physical, psychological, psychobiological, language, behavioral, social-emotional, and educational development of children. For example, the National Institute of Child Health and Human Development (NICHD) at NIH has taken a leadership role in advancing scientific knowledge regarding the acquisition of reading and mathematics skills, related learning disabilities, and language development and second language acquisition, as well as child maltreatment, childhood obesity, and the attainment of school readiness skills. Additionally, understanding normative brain development and its relationship to cognitive, social-emotional, and behavioral development is important in finding the causes of myriad childhood disorders related to mental retardation, mental illness, drug abuse, and pediatric neurological diseases, which can continue into adulthood. To define the healthy ranges in brain growth and development patterns in children as they mature, NIH-funded researchers are creating the Nation's first database of Magnetic Resonance Imaging measurement of normal brain development over time in children and adolescents in the United States. NIH is bringing together a diverse array of researchers to design and support a large-scale longitudinal study that uses state-of-the-art brain-imaging technologies and that collects clinical and behavioral data, which will be used to develop analytical software tools. A special effort will be made

to disseminate these data, and as a result, the scientific community will have access to a Web-based, user-friendly resource that integrates neuroanatomical and clinical/behavioral data to examine brain-behavior relationships and relationships between physical maturation and brain development.

Cancer Research

NIH investment in cancer research is helping to make a real difference. In the United States, death rates from all cancers combined dropped 1.1 percent per year from 1991 to 2001.[xxxviii] Yet cancer remains a major public health problem with more than 1 million Americans per year diagnosed with some form of cancer. Despite significant progress, the cancer challenge remains formidable, and NIH investment in basic cancer research remains critical. NIH will continue to support a broad range of basic research to expand the understanding of cancer. Through the *Cancer Genome Atlas Project,* NIH will expand the capacity of the cancer community to utilize information on cancer genes. NIH also will focus on a growing area of interest—understanding the reaction of the body's immune system to a developing tumor—because chronic inflammatory immune responses are known to exacerbate certain cancers.

Asthma

NIH supports a comprehensive asthma program to develop new approaches to prevent, treat, and control asthma. Asthma exacerbations cause many of the negative effects of asthma, and management of asthma exacerbations accounts for a large proportion of the estimated annual cost to the Nation's economy. In contrast to the understanding of the origins of asthma, little is known about the processes that occur during an acute episode; how worsening attacks are resolved; the effect of attacks on future severity and frequency; and the long-term effects on lung physiology, function, and disease progression. In order to develop new interventions to prevent and help resolve acute or worsening asthma episodes, NIH initiated a set of basic, clinical, and translational studies to determine the molecular, cellular, and genetic causes of asthma exacerbations. The long-term goal is to identify and characterize two molecular pathways of potential clinical significance that may serve as a basis for discovering new medications for preventing and treating the progression of this disease. The studies will address diverse areas including the role of environmental triggers in enhancing airway hyperresponsiveness; the relationship of environmental factors to frequency and severity of asthma attacks; specific effects of initiating events on lung physiology and inflammation; genetic approaches to individual susceptibility for worsening attacks; and the role specific immune and lung cells play in asthma disease classification, chemistry, and physiology.

Pandemic Influenza

HHS is working intensely against influenza. The center of this work is the development of multiple vaccines against influenza virus. At the level of basic science, however, NIH is collaborating with numerous public and private partners on an influenza sequencing project. This project will determine the complete genetic sequences of thousands of influenza virus strains, providing the scientific community with data vital to development of new vaccines, therapies, and diagnostics.

Antimicrobial Resistance

Microbes once easily controlled by antimicrobial drugs are causing infections that no longer respond to treatment with these drugs. In addition, new, serious, and unforeseen infectious disease threats have emerged, including those posed by agents of bioterrorism. Because the existing repertoire of antimicrobial medications may not provide an effective defense against newly emerging and resistant organisms and bioterrorism agents in the future, there is a need to develop new treatments that may be effective against a range of pathogens. NIH is working to develop a *universal antibiotic,* a drug effective against a wide spectrum of infectious diseases, to help address these challenges. NIH also is expanding its capacity for medicinal and combinatorial chemistry, library and database resources, and screening assays for use in identifying novel antimicrobial drugs.

Strategic Objective 4.3

Conduct and oversee applied research to improve health and well-being.

The application of basic scientific findings in the health and human service areas marks the next step along the continuum from basic research to practice. Numerous divisions within HHS conduct and provide oversight of applied research. These activities range from clinical trials for promising new pharmaceuticals and vaccines to behavioral research to identify effective approaches for reducing risky behaviors associated with infectious and chronic diseases. The performance indicators highlight clinical trials focused on improving treatment to those with both cardiovascular disease and diabetes and/or chronic kidney disease.

Birth Defects/Developmental Disabilities

CDC conducts a variety of applied research studies to advance the understanding of factors associated with birth defects and developmental disabilities in both children and adults. Over the next 5 years, CDC will identify and evaluate the role of new factors for birth defects and developmental disabilities. CDC also will initiate new and continue existing studies of candidate risk and protective factors associated with birth defects and developmental disabilities to identify potential intervention strategies.

Substance Abuse Treatment

Although research has demonstrated that substance abuse treatment can be effective in reducing substance use and addiction, few science-based interventions have been developed and tested widely within the health care field. The reasons for this are, in part, related to cultural and institutional barriers. In an effort to narrow the substance abuse treatment gap, recent substance abuse treatment studies have focused on deploying interventions in communities. NIH has adapted and is testing three substance abuse treatment approaches in an effort to bring research-based treatments to communities more rapidly. These substance abuse treatment protocols,

Brief Strategic Family Therapy, Seeking Safety, and *Motivational Enhancement Treatment,* are designed to reach specialized populations that are frequently underrepresented in drug and alcohol abuse research and are often underserved in drug and alcohol abuse treatment centers. The populations served include adolescents at high risk for substance addiction and their families and abused women, as well as members of minority groups.

Lung Cancer

Lung cancer is one of the leading causes of death in the United States, with an estimated 160,000 deaths occurring annually and an estimated incidence of 173,000 newly diagnosed cases each year.[xxxix] Only one-third of newly diagnosed cases are identified at a stage early enough to allow for effective therapeutic intervention, while more advanced stages of the disease are characterized by a median survival rate of less than 1 year. The development of new drug treatments for lung cancer has been slowed by difficulty in both early detection and measurement of early therapeutic drug response. NIH is supporting research to evaluate, validate, and compare varying functional imaging methods that could serve as more sensitive approaches to the measurement of early drug response than standard or conventional anatomic imaging techniques that are based on significant tumor shrinkage. NIH is striving to validate and to compare three imaging methods that could offer increased sensitivity over computed tomography as a means of assessing lung cancer response to therapy.

Obesity

Obesity is associated with numerous serious diseases, including type 2 diabetes, heart disease, stroke, osteoarthritis, gallstones, breathing problems, and certain cancers. Type 2 diabetes, formerly viewed as a disease of older adults, has been increasingly reported among children.

NIH is exploring lifestyle-based approaches to obesity prevention, including behavioral or environmental interventions, in settings such as schools, communities,

and homes. NIH will support at least two studies that will evaluate the effects on weight control of worksite interventions that include environmental components, and at least three studies will evaluate the effects of interventions delivered in primary care settings to treat and/or prevent obesity in children. Because maintenance of weight loss is a critical yet particularly difficult element of obesity treatment and prevention, NIH also will investigate novel ways to help individuals who have intentionally lost weight to keep the weight off for at least 2 years. Complementing these areas of investigation relevant to lifestyle interventions is research to evaluate the efficacy of different types of diets and physical activities.

Cardiovascular Disease

To improve the treatment of cardiovascular disease, NIH is working to develop and clinically apply one new imaging technique that will enable tracking the mobility of stem cells within cardiovascular tissues. Scientists are now devoting considerable effort to understanding the role of cytokine[17] production by stem cells rather than focusing solely on assessing their differentiation state and location *in vivo.* Despite the new focus on cytokine production, the importance of understanding stem cell differentiation remains a basic, important problem in regenerative medicine. A promising new approach for assessing differentiation has recently been reported in the literature. Scientists have inserted a reporter of calcium transients into stem cells, allowing scientists to determine whether stem cells are coupled productively to the normal heart during the regeneration process. Control of differentiation will be critical for the eventual success of cardiovascular cell-based therapy. Imaging methods to detect and monitor the differentiation process are now the focus of efforts in numerous laboratories. NIH is undertaking a multimodality imaging effort to develop tools to track cardiovascular stem cells *in vivo,* and ultimately in patients.

Public Health Protection

CDC's applied research portfolio targets four interrelated areas: healthy people in every stage of life, healthy people in healthy places, people prepared for emerging health threats (infectious, occupational, environmental, and terrorist threats), and healthy people in a healthy world. In support of the goals-directed research strategy, CDC has developed the *Advancing the Nation's Health: A Guide to Public Health Research Needs, 2006-2015.* This Research Guide is a comprehensive resource of critical national and global public health research priorities that will advance science and practice toward greater health impact.

17 Cytokine is a protein secreted by cells of the lymph system that affects the activity of other cells and is important in controlling inflammatory responses.

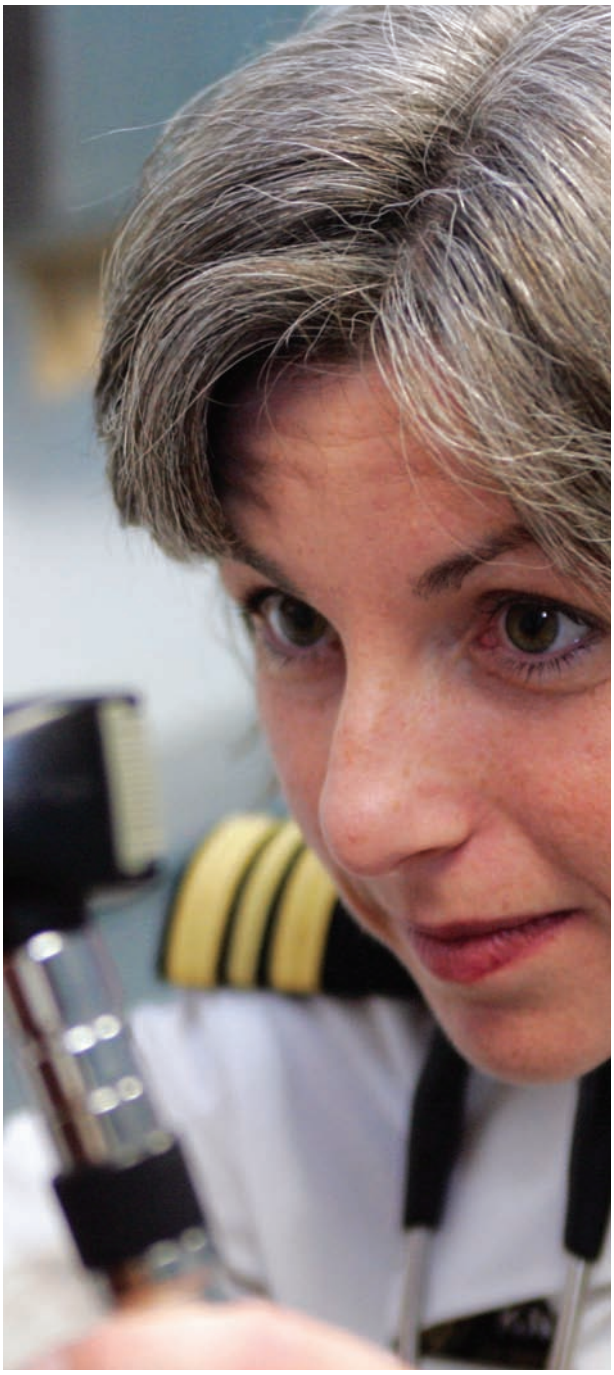
The array of public health research priorities includes infectious diseases, public health preparedness, chronic diseases and disabilities, safety of environments, global public health, health information and communication, crosscutting research, and health disparities. Over the next 5 years, CDC will progress toward achievement of the health protection goals and will address the research themes in the Research Guide.

Within the infectious disease area, research will focus on antimicrobial resistance; bioterrorism-related environmental microbiology, and zoonotic and vectorborne diseases; vaccines and immunization programs, including vaccine supply issues; and special populations. Within the preparedness area, research will focus on vulnerable populations, including predictive strategies for risk and recovery after an extreme event, infrastructure and workforce preparedness, and detection and diagnosis of hazards and their medical consequences.

The chronic disease applied research portfolio will focus on pregnancy planning and preconception care; optimal child and adolescent development; identification of effective health promotion strategies; and reduction of the burden of, disparities in, and risk factors for, chronic disease among older adults. In order to create safe places to live, work, and play, CDC will conduct research on environmental risk factors such as lead exposure and health, safe workplace design, effective strategies to prevent injuries and violence, and risk and protective factors for interpersonal violence and suicidal behavior.

Food, Drug, and Device Safety

Under its *Critical Path Initiative,* FDA will stimulate and facilitate a national effort to modernize the scientific process through which a potential human drug, biological product, or medical device is transformed from a discovery or "proof of concept" into a medical product. FDA will continue to conduct research on resistance of foodborne pathogens to antimicrobial drugs and to provide for the safe use of antimicrobials in food animals, while ensuring that the usefulness of critical human drugs is not compromised or lost.



FDA's National Center for Toxicological Research (NCTR) will undertake applied research studies that support and anticipate current and future regulatory needs, including integrated toxicological research and support for the *Critical Path Initiative.*

Strategic Objective 4.4

Communicate and transfer research results into clinical, public health, and human service practice.

The implementation of research results in the health care Americans receive every day is the last step of productive research. The performance indicators at the end of this chapter highlight three ongoing efforts to improve prevention efforts among older adults, reduce infant mortality among minorities, and implement evidence-based practices in clinical care.

Community Preventive Services

The *Guide to Community Preventive Services* serves as a filter for scientific literature on specific health problems that can be large, inconsistent, uneven in quality, and even inaccessible. This Community Guide summarizes what is known about the effectiveness, economic efficiency, and feasibility of interventions to promote community health and prevent disease. The *Task Force on Community Preventive Services,* convened by HHS, makes recommendations for the use of various interventions based on the evidence gathered in the rigorous, systematic scientific reviews of published studies conducted by the review teams of the Community Guide. The findings from the reviews are published in peer-reviewed journals and made available on this Internet Web site. HHS will continue to support the Community Guide and will disseminate its systematic review findings via its Web site.

Clinical Preventive Services

The *Guide to Clinical Preventive Services* provides recommendations on screening, counseling, and preventive medication topics and includes clinical considerations for each topic. This new pocket guide provides general practitioners, internists, family practitioners, pediatricians, nurses, and nurse practitioners with an authoritative source for making decisions about preventive services. HHS will continue to support the *Guide to Clinical Preventive Services* and disseminate its systematic review findings via its Web site.

HHS also supports a joint *Clinical Decision Support* program/project planning and coordination effort. This project will provide recommendations and an action plan designed to advance the development, widespread adoption, and value of clinical decision support in improving health and the quality and safety of health care delivery. AHRQ, CMS, IHS, and ONC are collaborators within HHS. The project also includes non-Federal partners, including the Certification Commission for Healthcare Information Technology, Thomas Macromedia, Brigham and Women's Hospital, Partners HealthCare, American Medical Informatics Association, and Oregon Health & Science University.

Dissemination of Findings

AHRQ plays an important role in translational research and dissemination of research findings. AHRQ conducts and supports research on value-based purchasing to help meet these information needs, including articles for the field on how to design, implement, and evaluate value-based purchasing programs. AHRQ's studies and reports will expedite the cycle of research so that purchasers have quicker access to findings on value-based purchasing and will provide guidance on decisionmaking related to value-based purchasing. AHRQ's *Accelerating Change and Transformation in Organization and Networks* program will promote innovation in health care delivery accelerating the development, implementation, dissemination, and uptake of demand-driven and evidence-based products, tools, strategies, and findings.

AHRQ's *Innovations Clearinghouse,* an online searchable database and repository of innovations in health service delivery, will capture effective methods of disseminating and sustaining improvements in the delivery of health care. In addition, the *Innovations Clearinghouse* will serve as a forum for learning about innovation and change. It will provide a national-level, publicly accessible mechanism for obtaining objective, detailed information on health care innovations and tools and will promote their dissemination, replication, adaptation, and use.

Dissemination of Information

HHS also develops and disseminates information and guidelines based on applied research results. For example, NIH continues to develop and disseminate guidance related to Sudden Infant Death Syndrome (SIDS). SIDS, a syndrome of unknown cause, is defined as the sudden death of an infant younger than 1 year of age, which remains unexplained even after a thorough case investigation, autopsy, and review of the clinical history. SIDS is the leading cause of postneonatal mortality in the United States. Led by NIH in collaboration with various sponsors, the *National Back to Sleep* public health education campaign was launched in 1994 after the American Academy of Pediatrics recommended back sleeping as the safest sleep position for infants younger than 1 year of age. Since the launch of the campaign, the SIDS rate has dropped by 50 percent.

However, despite the overall success of the campaign, African-American infants are placed to sleep on their stomachs more often than are White or Caucasian infants. The SIDS rate for African-American infants is two times greater than that of White or Caucasian infants. In collaboration with African-American organizations, NIH has developed comprehensive strategies to reduce SIDS in African-American communities. First, NIH launched a multiyear project to disseminate the American Academy of Pediatrics safe sleep guidelines in Mississippi. The project has multiple components, including training public health workers to convey SIDS risk reduction messages, developing partnerships with State and

local stakeholders, and providing minigrants to community and faith-based organizations to assist with their outreach efforts. Second, a continuing education curriculum has been developed for nurses on safe sleep guidelines and effective ways to convey the risk reduction message. This curriculum will be implemented at regional and national conferences.

Evidence-Based Practices

Several HHS operating divisions support grant programs that facilitate the utilization of evidence-based approaches. SAMHSA's *Strategic Prevention Framework State Incentive Grants,* e.g., require State grantees and their subrecipients to identify their substance use-related problems and to develop and implement evidence-based programs, policies, and practices that have been proven effective in addressing these issues. AoA funds a grant program and public/private partnership to increase older people's access to programs that have proven to be effective in reducing their risk of disease, disability, and injury. The partnership involves a variety of Federal agencies and private foundations that are coordinating their efforts to support the implementation of evidence-based disease prevention programs at the State and community levels.

In addition, the President's Budget for FY 2008 requests $10 million in new funding under the Child Abuse Prevention and Treatment Act to fund competitive grants. These grants will support the development of a statewide infrastructure to implement, monitor, and sustain high-quality, evidence-based nurse home visitation programs. Funds will be used to support and enhance collaboration and coordination across multiple State and private agencies that already receive Federal or State funding to implement various home visitation models. This new funding will be used for investments in cross-agency collaboration, program development, quality-assurance systems, training, technical assistance, workforce recruitment and retention, evaluation, and other administrative mechanisms needed to successfully implement and sustain high-quality, evidence-based home visitation programs that have strong fidelity to proven effective models.

These programs demonstrate how the results of research from HHS divisions, including NIH, CDC, and AHRQ, can be effectively translated into practice at the community level through service providers. HHS will continue its commitment to infuse evidence into practice through such discretionary programs.

National Registry

SAMHSA supports the *National Registry of Evidence-based Programs and Practices,* a Web-based system designed to disseminate timely and reliable information about interventions that prevent and/or treat mental and substance use disorders. Programs in the Registry have undergone a rigorous review. The Registry provides detailed descriptions of each intervention as well as outcome data.

Performance Indicators

		Most Recent Result	FY 2012 Target
Strategic Objective 4.1 **Strengthen the pool of qualified health and behavioral science researchers.**			
4.1.1	Through the National Research Service Award program, increase the probability that scientists continue participation in NIH-funded research within the following ten years: a) Post-doctoral fellows; and b) Pre-doctoral trainees and fellows.	 a) 13 percentage points; and b) 13 percentage points.	 a) 12+ percentage points; and b) 12+ percentage points.
Strategic Objective 4.2 **Increase basic scientific knowledge to improve human health and human development.**			
4.2.1	Develop and apply clinically one new imaging technique to enable tracking the mobility of stem cells within cardiovascular tissues.	Researchers in the NIH intramural program have developed probes that are compatible with optical microscopy techniques developed by intramural scientists.	Develop one new imaging technique that is able to be clinically applied.
4.2.2	Identify at least one clinical intervention that will delay the progression or onset of Alzheimer's disease (AD), or prevent it.	Nearly 1,000 new late-onset AD families have been identified and recruited to the AD Genetics Initiative.	Identify the next generation of compounds for testing in pilot clinical trials.
4.2.3	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.	The prototype pattern recognition algorithm has been designed and trained to recognize anomalies in the pilot study of brain Magnetic Resonance Spectroscopic Imaging (MRS) scans.	Apply, in conjunction with a Cooperative Research and Development Agreement (CRADA) partner, a pattern recognition algorithm to identify early biomarkers of brain disease to other disease endpoints in clinical applications such as those used to identify breast cancer markers.

		Most Recent Result	FY 2012 Target
Strategic Objective 4.3 Conduct and oversee applied research to improve health and well-being.			
4.3.1	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.	Initial findings made public at the annual American Diabetes Association meeting in June 2006.	Complete clinical trials and make results available.
Strategic Objective 4.4 Communicate and transfer research results into clinical, public health, and human service practice.			
4.4.1	Increase the number of AoA-supported community-based sites that use evidence-based disease and disability prevention programs.	27 sites	136 sites
4.4.2	Reduce the disparity between African-Americans infants and White infants in back sleeping by 50% to reduce the risk of Sudden Infant Death Syndrome (SIDS).	The SIDS rate for African-American infants is two times greater than that of White infants.	Reduce disparity by 50%
4.4.3	Reduce the financial cost (or burden) of upper gastrointestinal (GI) hospital admissions by implementing known research findings.	$93.46 per U.S. resident ages 65 to 85.	10% reduction

Note: Additional information about performance indicators is included in Appendix B.

Meeting External Challenges

Numerous external factors influence the Department's ability to advance its scientific research and development enterprise. The pace and uncertainty of progress in basic and applied research make it difficult to predict how and from where the next important advances will emerge. Additionally, applied research depends on advances in basic biomedical and behavioral research as a precondition of new work, the time often needed for a basic research finding to develop into a public health result, and drug testing time needed to develop animal models and move through the phases of clinical trials successfully.

Pace and Success of Research

In recent years, rapid advances in the biomedical sciences have raised expectations of similar progress in the development of products for the prevention and treatment of serious illnesses. Despite huge strides to decipher the intricacies of human biology, medicine today remains, to an unfortunate degree, an attempt to balance the risks of treatments against their uncertain potential to cure. Physicians earnestly attempting to provide the best treatments, along with their patients—who may be suffering from any of a host of debilitating, even fatal, diseases—are too often left waiting for treatments that are expensive and, ultimately, may not work for them. Compounding these problems

is the fact that the number of new drugs and other treatments approved each year for use in the United States is steadily dropping, in no small part because scientists test new discoveries using outdated and inefficient tools and techniques. The result is a slow, expensive process. It produces fewer and fewer treatments that can be approved as safe and effective, and it leaves consumers on their own to grapple with the question marks of treatment and a short list of prevention options.

One of HHS's primary strategies for reversing this trend is through the FDA *Critical Path Initiative* (CPI). The CPI identifies and prioritizes the most pressing medical product development problems and the greatest opportunities for rapid improvement in public health benefits. The goal is to stimulate the development of powerful new scientific and technical tools—such as proven biomarkers, innovative clinical trial designs, simulation models of physiology and disease processes, and manufacturing quality assessment methods—capable of rapidly predicting the safety, effectiveness, and quality of new medical products. Development of these tools will be based on an understanding of the most successful practices as well as the failures, roadblocks, bottlenecks, and missed opportunities along the way.

Business Interests

Within the research and development sector, business decisions, such as technical capabilities, competing opportunities, interest in the field to develop basic findings into next steps or the next generation of science, economic motivations, public health motivations, and other considerations, significantly influence research and development progress. For example, during the last half-century, pharmaceutical companies have been gradually abandoning the development and manufacture of vaccines. Today, fewer companies are making vaccines because of a number of factors, including the expense involved in bringing vaccines to market and the small size of the vaccine market compared to the larger drug market. There does not appear to be a single reason to explain the decline in the number of vaccine manufacturers. High-risk research that is critical to biomedical advances must often be initiated by public agencies; because of the high risk of failures, private for-profit groups may be less likely to pursue this type of research.

A larger trend in pharmaceutical company mergers and acquisitions, which has seen vaccine-only companies acquired by larger manufacturers, has also contributed to the decreases in the total number of companies making vaccines. In the 1990s, these mergers and acquisitions were largely driven by the need to cut costs. Companies are merging and acquiring other companies in order to secure enough capital and expertise to take advantage of these innovations and, at the same time, cut costs and create efficiencies. The concern remains, however, that leaving the manufacture of all vaccines in the hands of so few producers leaves the supply vulnerable to disruptions and shortages as has been observed in recent years regardless of the total capacity to produce vaccines. HHS is working with manufacturers to identify incentives to promote market reentry and capacity expansion.

Intellectual Property

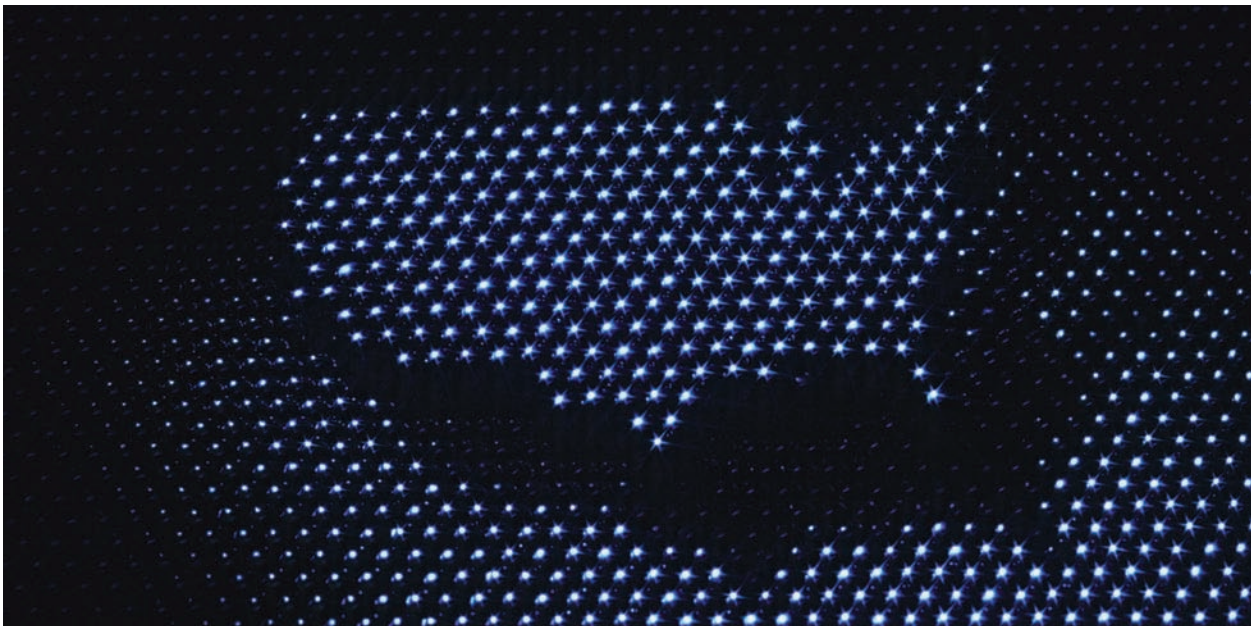
Intellectual property issues also influence the advancement of science. HHS is working to devise creative incentives to promote the sharing of knowledge among researchers. HHS is also working as a member of the global community to promote knowledge sharing across countries through formal and informal channels.

Recruiting and Retaining Expertise

The scientific labor market is highly competitive. A highly competitive labor market may impact HHS's ability to recruit and retain scientific experts to conduct and oversee research activities and to review applications for medical products. HHS will work to address this challenge by developing training and fellowship programs, as well as partnerships with academia, to enhance the pool of qualified scientists.

Chapter 6

Responsible Stewardship and Effective Management



Responsible Stewardship and Effective Management

Effective Human Capital Management
Effective Information Technology Management
Effective Resource Management
Effective Planning, Oversight, and Strategic Communications

This section of the *Strategic Plan* highlights the means and strategies employed by HHS's operating and staff divisions to support the achievement of the Department's goals. Many of these functions and activities are not seen by the citizens we serve; however, they are critical to our stakeholders and the HHS employees who implement our programs.

As the goals of this *Strategic Plan* make clear, HHS's core mission is to protect the health of all Americans and provide essential human services, especially for those who are least able to help themselves. Signs of the positive results of this mission come to light every day, as HHS employees develop cures for devastating diseases; research critical trends in public health; assist children, families, and older adults in living better lives; and perform countless other services for the Nation and the world. Less visible is the framework of planning, administration, and management that facilitates all of these accomplishments. The success of HHS's scientists, researchers, caregivers, inspectors, and technicians depends on the solid foundation provided by managers, contracting officers, analysts, accountants, human resource specialists, attorneys, and all the other support staff across the Department. A robust and reliable system of administrative support provides the necessary groundwork for the Department to remain dedicated to, focused on, and unhindered in its programmatic work.

A critical factor in the Department's achievement of its mission and goals is its ability to formulate, implement, execute, and manage effective administrative support for its programs—from exercising responsible stewardship of taxpayer dollars to managing employees effectively. Our underlying approach will be an interactive, ongoing effort to formulate policy and strategies, monitor progress and results, reward excellence, correct mistakes, and adjust to changing circumstances.

HHS continuously reviews and refines management practices as needed to ensure that the Department has the resources to provide first-rate administrative support. Through aligning its strategic plans, budgets, and performance plans and establishing measures that assess our progress and results, HHS clearly defines its intended outcomes, and effectively projects and manages resources required to implement programs.

This section of the *Strategic Plan* outlines the management means and strategies that HHS will employ to facilitate program success. In carrying out these strategies, the Department places the utmost importance on fostering a culture of leadership and accountability. All employees are expected to assume leadership roles in their areas of responsibility by exhibiting a willingness to develop and coach others, a commitment to teamwork and collaboration, and a drive to meet challenges with innovation and urgency.

Effective Human Capital Management

Recruit, develop, retain, and strategically manage a world-class HHS workforce.

Implement rigorous recruiting strategies to ensure the hiring of top talent. Approximately a quarter of all HHS nonsupervisory employees, and about half of all HHS managers, will be eligible for retirement within the 5 years covered under this *Strategic Plan*. To ensure that future workforce needs are met, HHS has identified its mission-critical and core competencies and will continue highly targeted recruitment efforts. Among the strategies the Department will use are *Cooperative Education Programs,* the *Direct-Hire Program,* the *Federal Career Intern Program,* the *HHS Emerging Leaders Program,* the *Presidential Management Fellows Program,* and the *Retired Annuitants* hiring process. HHS will aggressively identify robust technology systems that will enable the Department to compete with private industry for top talent. In addition, HHS will continually examine recruitment processes to ensure that it improves the quality of the candidates recruited and is able to hire them in the quickest timeframe possible.

Strengthen the workforce by developing staff skills, improving competencies, and retaining talent. HHS will develop an effective learning and development strategy that leverages current capabilities at HHS University and also takes advantage of training opportunities in the operating divisions. Emphasis will be placed on achieving better results through more effective utilization of the Department's training-related financial resources. To ensure that resources are allocated to produce maximum effectiveness in an optimal timeframe, HHS will support this activity through traditional classroom training, online self-study, development programs, and career counseling. In addition, the HHS Web-based, Departmentwide Learning Management System supports closing competency gaps (core and technical) in mission-critical occupations.

Ensure that the HHS workforce reflects the diversity of the Nation it serves. A diverse workforce capitalizes on the contributions of persons of distinct ethnicities, races, cultures, and backgrounds. Leveraging these differences enhances the social and business workplace environment, helps to eradicate discrimination, and increases organizational efficiency and productivity. Through personal leadership and involvement, all HHS employees will proactively support and promote the Department's Equal Employment Opportunity (EEO) and Diversity Management programs to achieve a more diverse workforce and promote a workplace free of discrimination. Through program accountability, training, outreach, recruitment, and use of flexible hiring techniques, HHS will ensure that representation of minorities and persons with disabilities at HHS reflects the Nation as a whole.

HHS has some specific initiatives to recruit underrepresented populations. HHS, through its partnership with the U.S. Department of Defense Computer/Electronic Accommodations Program and the U.S. Department of Labor Workforce Recruitment Program, plans to leverage these resources to increase hiring of people with disabilities. In addition, HHS minority outreach initiatives include participation in a number of student intern programs, such as the *Asian Pacific American Institute for Congressional Studies, Bilingual/Bicultural Program, Federal Career Intern Program, HHS Emerging Leaders Program, Hispanic Association of Colleges and Universities National Internship Program, International Leadership Foundation,* and *the Organization of Chinese Americans Government Internship Programs.* In the area of training, HHS has developed the EEO and Diversity Academy, which offers courses designed to instill in hiring managers, as well as all in HHS employees, recognition of the intrinsic value a diverse Federal workforce brings to a Department with a diverse customer base.

Ensure the highest level of efficiency and effectiveness of HHS organizations, through regular competition with the private sector. In accordance with OMB Circular A-76,[XL] HHS will continue to ensure that the most efficient organization carries out the Department's commercial functions. HHS will utilize a combination of standard studies, streamlined studies, and restructuring efforts to implement competitive sourcing. The savings generated from competitive sourcing studies will continue to provide benefits to HHS programs and the American taxpayer.

Ensure that all HHS employees are accountable for results. Guided by the Department's Human Capital Accountability System Policy, HHS will continue to monitor, manage, and evaluate its formal Departmentwide, integrated human capital accountability system to ensure mission-aligned human capital goals are achieved effectively, efficiently, and within merit system principles and related regulations. All HHS employees will have an approved performance plan in place within 30 days of hire and will receive at least one midyear progress review annually. The *Senior Executive Service and Organizational Performance Management System* and the *Performance Management Appraisal Program* will connect expectations to mission and link performance ratings with measurable outcomes. Performance plans for all HHS employees are designed to cascade from the goals and objectives outlined in the *Strategic Plan* and operating division strategic plans, to ensure that performance expectations

throughout the entire agency are aligned with the HHS mission and oriented toward achieving results.[18]

Effective Information Technology Management

Provide a well-managed and secure enterprise information technology environment.[19]

Development of a comprehensive plan that optimizes the use of resources in support of all strategic and management goals and objectives. The Clinger-Cohen Act of 1996 (Public Law 104-106) requires that every Federal agency develop an Enterprise Architecture (EA). EA ensures that the business and technical architectures for the Department support the HHS mission and outcome objectives by establishing relationships between and among business operations and the information systems and resources that enable those operations. EA takes a comprehensive view of the enterprise, including strategic planning, organizational development, relationship management, business process improvement, information and knowledge management, and operations. EA will enable the Department to achieve more effective planning and control over investments for information technology by enhancing flexibility and interoperability across information systems; reducing redundancies; and improving access to accurate, timely, and consistent information.

Maintain a secure environment in which all aspects of security, privacy, and confidentiality are addressed. HHS is an attractive high-profile target for hackers and those with malicious intent seeking sensitive medical information, homeland security first responder information, patent and intellectual property worth billions of dollars, and much more. In order to address these immediate challenges and comply with Federal legislation, HHS has developed a proactive, enterprisewide information technology (IT) security program (*Secure One HHS*) to help protect the HHS IT infrastructure against potential threats and vulnerabilities. The *Secure One HHS IT Security Program* was designed to increase the baseline IT security posture across all HHS operating divisions while reducing reporting burdens for compliance with Federal mandates. The creation of this new security program, which spans the HHS IT community, Headquarters, and the operating divisions, is an important step in protecting HHS's ability to provide mission-critical services and maintain the public's trust and confidence in the quality of HHS services and business operations.

Manage information technology projects and investment to demonstrate results and consistently provide the value intended. This activity will require the successful completion of all aspects of project and investment management rigor that are described in the *HHS Enterprise Performance Life Cycle* (the integration of management, business, and engineering life-cycle processes that span the enterprise to align IT with the business). This success will be measured by the *HHS Capital Planning and Investment Control* process, which structures budget formulation and execution, ensures that investments consistently support the strategic goals of the agency, and includes the evaluation of effective earned value management.

Effective Resource Management

Use financial and capital resources appropriately, efficiently, and effectively.

Ensure the integrity of HHS financial management processes. Financial management systems that meet *Joint Financial Management Improvement Plan* certification standards will be in place Departmentwide by 2010, with all but Medicare Parts C and D covered by the beginning of FY 2010. HHS also will address all identified outstanding material weaknesses and internal control deficiencies.

Manage financial resources wisely and appropriately through the reduction of improper payments. According to the Improper Payments Information Act of 2002 (Public Law 107-300), improper payments occur when funding is provided to the correct recipient in the incorrect amount, when the wrong recipient receives funds, or when funds are used by the recipient improperly. HHS will continue its efforts to reduce the rates of improper payment in three of its largest

18 Appendix C, Performance Plan Linkage, provides additional information on these strategies.

19 Additional information about HHS's information technology strategies is included in the Information Technology section.

programs, Medicare, Head Start, and Foster Care. At the same time, the agency will develop improved information on payment error rates for other large programs such as Medicaid, State Children's Health Insurance Program (SCHIP), and Temporary Assistance for Needy Families (TANF).

Strategically manage the acquisition, leasing, construction, operation, maintenance, and disposal of HHS's real property assets. HHS will oversee effective real property acquisition and operations and maintenance practices, right size the real property portfolio, and realize cost savings through increased efficiency and strategic investments. Efficiency and effectiveness of real property assets will be maximized by disposing of excess property and reducing underutilization and overutilization. HHS will improve both the condition of HHS's buildings and facilities and environmental management through greater energy conservation, enhanced occupational safety and health, and sustainable development.

Create a seamless integration of acquisition policies, procedures, systems, and contract vehicles to better serve employees, customers, and vendors. Through the *Acquisition Integration and Modernization* initiative, HHS will develop a uniform way of conducting business, minimize duplication and improve efficiency, and provide excellent customer service to HHS stakeholders. In addition, HHS will facilitate mobility among HHS acquisition personnel as well as personnel interfacing with the acquisition community, leverage spend opportunities and drive cost savings, capture knowledge and share best practices within the acquisition community, ensure sufficient resources to conduct acquisition activities, and ensure an optimal allocation of these resources as efficiencies are realized.

Improve coordination of grant activities across the Department. HHS will implement a grant announcement planning and review process (linked to budget plans) that ensures alignment of planned grant announcements with Departmentwide priorities, identifies opportunities for collaboration across the Department, and gives the public advance information on grant announcement plans.

Effective Planning, Oversight, and Strategic Communications

Improve the management of HHS by providing ongoing oversight, evaluation, and analysis of policies and programs and by ensuring effective strategic communications.

Provide ongoing oversight, evaluation, and analysis of policies and programs. We will monitor our programs to ensure that the Department is fulfilling its statutory, regulatory, and fiduciary responsibilities and intergovernmental commitments in an ethical and legal manner. In addition, we will conduct independent and objective audits, evaluations, analysis, and investigations to assess the effectiveness and efficiency of policy and program implementation.

Improve communication with the public, employees, and stakeholders about HHS's mission, goals, and performance, as well as the benefits and services that the Department provides. We will improve communications by proactively developing, maintaining, and widely disseminating comprehensive and accurate information about our plans, activities, and accomplishments in a timely manner to our employees, stakeholders, and customers. In addition, we will endeavor to respond promptly to requests for information from members of the U.S. Congress, our other stakeholders and partners, local and national media, and the public regarding HHS policies and programs.

Effective human capital, information technology, resource management, and management oversight and communications are HHS's most critical means to provide support for the Department's goals and strategies. HHS will continue to analyze its practices and procedures to ensure that the management strategies defined for the future meet the needs of the Department and, most importantly, its customers: the American people.

APPENDIX A

HHS Program Evaluation Efforts

HHS Program Evaluation Efforts

Evaluations play an integral role in carrying out the HHS mission. Evaluation assesses the efficiency, effectiveness, and responsiveness of the Department's programs or strategies through the analysis of data or information collected scientifically. It also ensures the effective use of resulting information in strategic planning, program or policy decisionmaking, and program improvement.

HHS evaluation planning activities are coordinated with Departmentwide planning initiatives. HHS evaluation activities support the Department's strategic planning and performance management activities in several ways. Completed evaluation studies help programs determine the means and strategies they will use to achieve HHS strategic goals and objectives. Program evaluations also may identify data that programs can use to measure performance. A sample of current evaluations is listed in Table A-1. Also listed are future evaluations that will inform strategic planning. HHS divisions use findings from their evaluations to support the Government Performance and Results Act (GPRA) of 1993 (Public Law 103-62) annual performance reporting to the U.S. Congress and program budget justifications of various HHS programs. Evaluation findings provide important sources of information and evidence about the success of policies and programs.

Typically, HHS evaluation priorities include congressionally mandated program evaluations, evaluations of Secretarial program or policy initiatives, assessments of new programs, evaluations of programs that are candidates for reauthorization, and reviews of program performance that support management decisionmaking and accountability.

The U.S. Congress requests that HHS coordinate all of its Research, Demonstration, and Evaluation (RD&E) programs to ensure that the results of these projects address HHS program goals and objectives. HHS reports to the Congress annually on RD&E activities. The Assistant Secretary for Planning and Evaluation (ASPE) and the Assistant Secretary for Resources and Technology (ASRT) work together with HHS divisions to provide the Congress with a special annual research, demonstration, and evaluation budget plan that coincides with the preparation of the President's fiscal year budget. The plan outlines HHS RD&E priorities as related to the Department's strategic goals and objectives.

Evaluation Oversight

HHS divisions and ASPE execute annual evaluation plans that involve developing evaluation contracts and disseminating and applying evaluation results. All divisions and their subunits (centers, institutes, and bureaus) coordinate with each other on research and evaluation project planning and release of final reports that relate to work of other HHS divisions. Although there is some oversight responsibility and execution capability in the Office of the Director or Administrator for each division, the various subunits conduct much of the day-to-day evaluation activity.

The Office of Inspector General (OIG) performs independent evaluations, also called inspections. The OIG mission includes providing HHS, the U.S. Congress, and the public with evaluations that focus on preventing fraud, waste, or abuse; promoting economy, efficiency, and effectiveness in Departmental programs; and presenting practical recommendations for improving program operations.[XLI]

Quality Assurance and Improvement

Most evaluation projects are developed at the program or office level. A committee of division- or office-level policy and planning staff members generally conducts the initial quality review. Before a project is approved, a second committee reviews it for technical quality with expertise in evaluation methodology. Technical review committees follow a set of criteria for quality evaluation practice established by each division. ASPE, for example, has a formalized peer review process in which experienced evaluators on staff review, discuss, and approve all proposed research projects before they are submitted for funding. Some HHS divisions have external evaluation review committees composed of evaluation experts from universities and research centers.

HHS uses a variety of program evaluation techniques to review the effectiveness of programs and to ensure that programs are on target so that HHS can meet its strategic goals. Comprehensive, independent evaluations are an important component of the HHS strategy to improve overall program effectiveness and to ensure that the goals identified in the *Strategic Plan* accurately represent HHS's progress in achieving its goals. These evaluations are an important component in evaluating whether or not programs are effective, well designed, and well managed.

Program Assessment Rating Tool

The *Program Assessment Rating Tool* (PART) was created to improve program performance and inform funding and management decisions throughout the Federal Government. From CYs 2002–2006, HHS reviewed nearly all programs using the PART. The review process involved with PART helps to identify each program's strengths and growth areas through a comprehensive analysis of the program's purpose and design; performance measurement, evaluation, and strategic planning; program management; and program results.

After a PART review, programs implement a series of followup actions to improve program effectiveness. PART results may lead programs to develop new performance indicators, conduct independent evaluations of program activities, request legislative changes to the program structure, or make a series of other program improvements. The *Strategic Plan* highlights several measures developed during the PART process.

Role of Program Evaluations in Strategic Planning

As noted above, evaluations play an important role in setting the goals and objectives in strategic planning. Examples follow below.

Strategic Goal 1: Health Care

By closely monitoring the implementation of the new Medicare prescription drug benefit and the capacity to respond to Medicare beneficiaries' questions, HHS was able to provide the resources needed to improve the ability of beneficiaries, and the others who assist them, to obtain the information they needed to enroll in a drug plan. In addition, the demographic and other information developed to describe Medicaid beneficiaries and the uninsured are helping policymakers determine how to address these issues.

Success in increasing health care service and availability relies, in part, on how effectively we are able to ensure the successful translation of research into safe and effective medical products. Evaluation information supports our ability to help human drug sponsors improve the quality of their drug development and related new drug applications. The Prescription Drug and User Fee Act of 1992 (Public Law 102-571), as amended (PDUFA III), effective from FYs 2003–2007, expanded user fee funding to support several initiatives to improve application submissions and FDA-sponsored interactions during drug development and application review. FY 2005 was the fifth consecutive year in which FDA received an increased number of priority original drug applications, which represent significant new medical treatments for American patients. Additionally, FDA found that new mechanisms for FDA-sponsored interactions, such as meetings and consultations during the drug development phase, had a positive impact on the rate of first-cycle approval of drug applications, which speeds the availability of safe and effective new medical treatments to patients.

Through the Medicaid program, a substantial number of people receive personal assistance services, which allow them to function independently in their own homes. Consumer-directed services further allow beneficiaries to manage not only their human assistance, but also other covered supportive services. *Cash and Counseling* is an expanded model of consumer-directed services. ASPE and the Robert Wood Johnson Foundation collaborated to fund the *Cash and Counseling Demonstration Evaluation* (CCDE) to track the experiences of beneficiaries and providers in three States—Florida, Arkansas, and New Jersey—that participated in a unique Medicaid waiver experiment. Because of the CCDE, 11 other States have been selected to participate in an expansion of *Cash and Counseling.* Equally important, consumer choice, control, and empowerment have been inculcated throughout the Medicaid program and are reflected in many of the long-term care initiatives highlighted in this *Strategic Plan*, including the *Money Follows the Person* demonstration.

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

The development of food labeling information strategies was based in part on information from the *FDA Health and Diet Survey – 2004 Supplement.* Through the data gained from this survey, we were able to identify that most people have a limited understanding of most dietary fats and their relationship to the risk of coronary heart disease. In addition, we gained new information on consumer attitudes toward diet, health, and physical activity.

As a part of a wide-ranging effort to improve patient safety, in 2004 FDA finalized a rule requiring barcodes on the labels of thousands of human drugs and biological products. The measure is to protect patients from preventable medication errors by helping ensure that

health professionals give patients the right drugs at the appropriate doses. FDA estimates that the rule will help prevent nearly 500,000 adverse events and transfusion errors while saving $93 billion in health care costs over 20 years.

Obesity has reached epidemic levels and is a primary focus of many HHS public health interventions. However, little is known about the dynamics of how obesity affects disability and other health outcomes as people age. To help inform policy and programmatic decisions around research and interventions aimed at preventing and treating obesity and alleviating its potential effects on disability and other health outcomes, ASPE is analyzing data from the *Health and Retirement Survey* as well as the *Assets and Health Dynamics Among the Oldest Old Study.* These data will expand our understanding of how obesity affects disability and other health outcomes as people move from late adulthood to older ages.

Strategic Goal 3: Human Services

The *National Evaluation of Welfare-to-Work Strategies* and the State welfare waiver evaluations found that mandatory welfare employment programs that employed a work-first approach are effective in increasing the employment and earnings of welfare recipients, particularly long-term recipients. These findings helped to influence the provisions of the Deficit Reduction Act of 2005 (Public Law 109-171) that strengthen the TANF work requirements.

Early findings from the *Family and Child Experiences Survey* (FACES) showed that Head Start children were not performing well in the area of letter identification and vocabulary. These findings motivated Head Start's intensive efforts to strengthen children's preliteracy. According to more recent FACES data, Head Start children are coming closer to national norms for letter recognition. The percentage of Head Start parents reading to their children three or more times a week has also increased, after intensive efforts to improve early literacy activities. Head Start anticipates continued gains as it continues to focus training and technical assistance resources in this area.

ASPE conducted a study to assess the costs of providing supportive services to individuals and families who are experiencing homelessness and residing in the homeless assistance programs through the U.S. Department of Housing and Urban Development (HUD). The findings identified the actual cost of these services and the myriad funding streams used. The study findings helped guide subsequent HHS and Administration policies on supportive services for individuals and families experiencing homelessness, particularly those residing in HUD homeless assistance programs.

Strategic Goal 4: Scientific Research and Development

AHRQ sponsored the *Combining Clinical and Administrative Hospital Data Evaluation* project. AHRQ also identified the most efficient set of clinical data elements that can be added to administrative data to increase the reliability and validity of hospital-specific public quality reporting. The intent was to develop mixed clinical-administrative data models that are clinically sound and defensible. The study focused on adding key clinical data elements to specific measures from the AHRQ Quality Indicators (QIs) to create clinically enhanced QIs.

Health information technology (health IT) is increasingly viewed as a tool that can promote quality and cost-effective care in the United States. Although much progress has been made in the development of electronic health records and other infrastructure, the lack of robust evidence on health IT costs and benefits across settings has stymied efforts to develop such capabilities in the post-acute care (PAC) and long-term care environment. A deeper, evidence-based understanding of costs and benefits is needed and is essential to inform providers contemplating purchase of health IT systems. In addition, such an understanding can provide useful and reliable information to policymakers, payers, employers, and others who seek to influence health IT adoption. ASPE is designing an evaluation to assess the business case for health IT in PAC and long-term care settings and to provide additional support for a keystone of the Department's vision for the health care delivery system of the future.

Table A-1

Selected Current Program Evaluation Efforts

Division	Topic	Description
Strategic Goal 1: Health Care		
AHRQ	Long-term care	Evaluate outcome measures and hold an expert meeting to improve use of long-term care tools.
AHRQ	Market forces	Evaluate research utility on health care cost, productivity, organization, and market forces.
AHRQ	Pharmaceutical outcomes	Evaluate research goals, impact, and progress reporting and use appreciative inquiry.
AHRQ	National Resource Center (NRC)	Evaluate the NRC program and the NRC Web site.
ASPE	Accuracy of Medicaid enrollment	Evaluating data from several sources to determine the accuracy of the estimate of Medicaid enrollment is correct and the accuracy of the estimate of the number of uninsured people.
ASPE	Advance directives	Analyze existing advance care planning efforts, prepare papers on selected topics, and conduct roundtable discussions with leading experts and persons with disabilities in order to develop a framework for a report from the Secretary to Congress on promoting the use of advance directives.
ASPE	Cash and Counseling	Encourage and facilitate the diffusion of the Cash and Counseling model of consumer-directed home and community-based services to 11 additional States.
ASPE	Employer health insurance	Measure changes in costs of and access to employer health insurance in a standardized and comparable way. The research will produce information to support increased access to affordable health care coverage.
ASPE	Graduate Medical Education (GME)	Assess the current state of GME, including sources of funding, characteristics of residency programs, and resident demographics. Evaluated strengths and weaknesses of current system of funding, and analyzed alternative models of funding and support.
ASPE	Health care quality	Completing a project to design evaluations of the Medicare Quality Improvement Organizations and will plan to fund projects to evaluate their performance.
ASPE	Impacts on premiums of changes in plan benefit design	Develop models that calculate the impact that changes in plan benefit design have on premiums.
ASPE	Implementation of Medicare Part D payments	Collecting and analyzing data measures associated with the implementation of the Part D benefit including enrollment, pharmacist inquiries, and helpline call volume.
ASPE	Massachusetts universal health coverage	Monitoring the implementation of the Massachusetts initiative to achieve universal health insurance coverage.
ASPE	Medicaid and SCHIP participation	Evaluate the effectiveness of outreach and retention efforts in improving participation in Medicaid and SCHIP.
ASPE	Medicare beneficiaries in integrated hospital systems	Examining utilization patterns of Medicare beneficiaries treated in integrated hospital systems, including the sites of care after acute hospitalization.

Division	Topic	Description
Strategic Goal 1: Health Care		
ASPE	Medicare Part D payments	Evaluate risk adjustment used to establish Part D payments to plans with regard to low- income and institutionalized beneficiaries.
ASPE	Medicare physician services	Assess value-based purchasing options for Medicare physician services used by other payers to examine elements that could be used in Medicare.
ASPE	Mental health prevention and treatment education	Conducting an evaluation of the impact and distribution of the Office of Women's Health's publication, "People's Piece on Mental Health."
ASPE	Mental Health Workforce Development and Retention	Identify gaps in the Nation's mental health workforce and to determine what efforts need to be implemented to retain a highly skilled workforce.
ASPE	National Medicare Education Program	Designing an evaluation of the National Medicare Education Program, a multifaceted educational and social marketing campaign intended to inform beneficiaries and their caretakers about health benefits under the Medicare program.
ASPE	Own Your Future	Conduct a followup survey of respondents in five States that participated in the long-term care awareness campaign entitled "Own Your Future," which encourages consumers to plan ahead for long-term care.
ASPE	Palliative end-of-life care	Develop a policy and research conceptual framework to help guide future Medicare efforts in palliative end-of-life care.
ASPE	Payments in ambulatory sites of service	Evaluating the differences between payments for the same services in different ambulatory sites of service.
ASPE	Quality of Long-Term Care	Examine whether the current approach to Medicare home health care quality adequately captures the potential differences in post-acute care and chronically ill patients.
ASPE	Regional patterns in drug utilization	Evaluate regional patterns in drug utilization to determine whether these patterns should be accounted for in the Part D payment rates.
ASPE	State health care reform programs	Evaluate State health care reform programs and their implementation, and focus on the employer response to these programs in particular. This research can be expected to guide States and Federal proposals to expand access to health insurance coverage using premium assistance, private insurance market reform, and employer-sponsored insurance.
CDC	Community-based interventions for alcohol-impaired driving	Evaluate interventions to decrease alcohol-impaired driving in community settings and its resulting deaths and injuries.
CDC	Community-based interventions to reduce motor vehicle-related injuries	Evaluate community-based interventions with demonstrated effectiveness for preventing motor vehicle-related injuries.
CDC	Fall prevention	Evaluate the translation of an exercise intervention that rigorous research has shown is effective in reducing falls among older adults, into a program.
CDC	Management of the learning-to-drive process	Evaluate the effectiveness of the Checkpoints intervention to measure the restrictions that parents place on their teens as they move from learner's permit to provisional license to full licensure.

Division	Topic	Description
Strategic Goal 1: Health Care		
CDC	Multilevel parent training	Evaluate the effectiveness of a multilevel parent training program for families with children 6 and younger.
CDC	National Breast and Cervical Cancer Early Detection Program	Evaluate the variation in diagnostic followup rates among different racial and ethnic groups.
CDC	Prevention of child maltreatment	Evaluate the strategies and techniques for reducing attrition and enhancing compliance with extant parenting programs for the prevention of child maltreatment.
CDC	Risk and protective factors for sexual violence perpetration and the overlap with bullying behavior	Evaluate the association between bullying experiences and co-occurring and subsequent sexual violence perpetration.
CDC	Teen driving safety	Evaluate the effectiveness of enhanced enforcement through teen self-reports on the number of passengers, adherence to nighttime curfews, seat belt use, and perceptions of police enforcement activity.
CDC	Training skills of home visitors	Evaluate the impact of home visitor training and factors related to the implementation (i.e., competency of visitors providing services, as well as adequate coverage of content according to a prespecified protocol) of an existing efficacious or effective home visiting program on family outcomes of child maltreatment and risk behaviors for youth violence (e.g., poor parent-child relations and/or harsh, lax, or inconsistent discipline).
CMS	Outpatient therapy utilization	Evaluate the impact of the Balanced Budget Act of 1997 (Public Law 105-33) on the delivery and utilization of inpatient and outpatient rehabilitation therapy services to beneficiaries.
CMS	Cancer prevention and treatment demonstration	Evaluate the success in eliminating or reducing disparities in cancer screening rates through timely facilitation of diagnostic testing, appropriate treatment modalities, cost-effectiveness of each demonstration, quality of services provided, and beneficiary and provider satisfaction.
CMS	Evaluate disease management programs in Medicare	Evaluate the effectiveness of Capitated Disease Management Demonstration for beneficiaries with chronic medical conditions and another demonstration of disease management focusing on beneficiaries with advanced stage diabetes and congestive heart failure.
CMS	Competitive bidding for Medicare clinical laboratory services	Evaluate a demonstration of testing of competitive bidding for clinical laboratory services under a demonstration project.
CMS	Direct Service Community Workforce	Develop a site-specific evaluation plan, develop a Web-based reporting tool, develop an evaluation design for the National Demonstration Program, and develop a series of promising practices to improve the recruitment and retention of direct service workers, for 10 demonstration projects.
CMS	End stage renal disease management	Evaluate the end stage renal disease management to determine case-mix, patient satisfaction, outcomes, quality of care, and costs and payments.

Division	Topic	Description
Strategic Goal 1: Health Care		
CMS	Health insurance flexibility	Evaluate the strength of the relationship between the Health Insurance Flexibility and Accountability initiative and the number and rate of uninsured for health care.
CMS	Informatics, Telemedicine, and Education Demonstration	Evaluate the telemedicine diabetes demonstration.
CMS	Life Masters Demonstration	Evaluate the combination of the State's Medicaid pharmacy benefit with a disease management activity funded by Medicare.
CMS	Long-Term Care Hospital Payment System Refinement	Evaluate the Long-Term Care Hospital Payment System Refinement and its effect on overall Medicare payments, and determine the feasibility of CMS establishing facility- and patient-level criteria for Long-Term Care Hospital payments.
CMS	Maintaining independence and employment	Evaluate several demonstrations providing supplemental Medicaid benefits to persons with HIV/AIDS.
CMS	Medical Adult Day-Care Services Demonstration	Evaluate the Medical Adult Day-Care Services Demonstration to determine the impact on patient outcomes and costs of furnishing care.
CMS	Alternative models for delivery of care to Medicare beneficiaries	Evaluate the implementation and operational experiences of participating Medicare Advantage Special Needs Plans, Medicare Care Management participating medical practices, Medicare Preferred Provider Organizations, Medicare Coordinated Care Demonstration, Medicare Health Care Quality Demonstration, Medicare Health Support, and Medicare Savings Accounts.
CMS	Medicare Lifestyle Modification Program Demonstration	Evaluate the health outcomes and cost-effectiveness of the Medicare Lifestyle Modification Program Demonstration for Medicare beneficiaries with coronary artery disease.
CMS	MMA's changes on dual eligible beneficiaries in demonstration and other managed care and fee-for-service arrangements	Evaluate the changes of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 (Public Law 108-173) on beneficiaries in dual eligible Medicare Advantage Special Needs Plans demonstrations that also contract for comprehensive Medicaid benefits.
CMS	Medicare Part D	Evaluate the Medicare Part D payment demonstration that represents an alternative payment approach for private plans offering prescription drug coverage under Part D.
CMS	Quality of health care	Evaluate components of two CMS quality initiatives—Nursing Home Compare and Home Health Compare.
CMS	Value-based purchasing	Evaluate the quality of care furnished to Medicare beneficiaries in nursing facilities and, in a separate demonstration, physician group practice, as part of a value-based purchasing initiative.
CMS	Program of All-Inclusive Care for the Elderly (PACE) as a permanent program	Evaluate PACE in terms of site attributes, patient characteristics, and utilization data statistically analyzed across sample sites and compared to the prior demonstration data and other comparable populations.
CMS	Rural Hospice Demonstration	Evaluate the impact of the Rural Hospice Demonstration on changes in the access and cost of care and to assess the quality of care for Medicare beneficiaries.

Division	Topic	Description
Strategic Goal 1: Health Care		
CMS	Senior Risk Reduction Demonstration	Evaluate health promotion and disease prevention using health-risk assessments, as well as ongoing tailored feedback, counseling, and referrals to local and national resources.
CMS	State pharmacy assistance programs	Evaluate two State pharmacy programs that have expanded Medicaid pharmacy coverage to low-income residents otherwise not Medicaid eligible.
CMS	System Change Grants	Evaluate the Real Choice Systems Change Grants including Comprehensive Family to Family, Housing, Life Accounts, Mental Health System Transformation, Portals from EPDST to Adult Supports, Rebalancing, and Quality Assurance and Quality Improvement in Home and Community-Based Services.
HRSA	Community-based insurance models	Evaluate current experience with existing models of community-based insurance products designed to make insurance affordable for low-income individuals. This evaluation relates to a range of safety-net programs that need to maximize reimbursement to cover the costs of serving the uninsured.
HRSA	State Medicaid opportunities for HRSA grantees	Evaluate changes in the national Medicaid program, and the impact of those changes on HRSA grantees in the respective States. This study is focused on the changes made in Medicaid by the States as they develop their systems, the impact on safety-net providers such as Health Centers, and opportunities for such providers to participate in State systems.
HRSA	Value and cost of providing comprehensive pharmacy services	Evaluate the value and cost to safety-net providers of providing comprehensive pharmacy services.
IHS	White Earth Health Center	Evaluate changes in center service and health status of patients.
NIH	Continuing Medical Education	Evaluate NIH Medical Education Program Continuing Medical Education to determine whether the program is operating as planned, is meeting regulatory criteria, and is achieving areas for program improvement.
SAMHSA	Co-Occurring State Incentive Grant (COSIG)	Evaluate to what extent SAMHSA's goals and objectives for the COSIG program were met; the strengths and weaknesses of the "State incentive grant" approach to helping States improve their systems of services for specific populations; and how SAMHSA can structure and support similar programs in the future.
SAMHSA	HIV Services Collaborative	Evaluate the HIV Services Collaborative, which supports SAMHSA's health oversight role, providing data and analyses, as well as definitive documentation of the benefits of program efforts to assist clinicians and program administrators in strengthening programs; in tailoring outreach and recruitment efforts; in better documenting the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition,* diagnoses within treatment populations; and in determining mental health staffing needs.

Division	Topic	Description
Strategic Goal 1: Health Care		
SAMHSA	National Child Traumatic Stress Initiative (NCTSI)	Evaluate the program to describe the children and families served by the NCTSI centers; describe the behavioral and clinical outcomes of children served; describe services utilized; assess the development and dissemination of effective products, treatments, and services; assess intranetwork collaboration; and assess the network's national impact.
SAMHSA	Screening, Brief Intervention, and Referral and Treatment (SBIRT) program	Evaluate the program in various settings and under somewhat different approaches to determine which models of SBIRT offer the greatest potential to improve the Nation's service system.
SAMHSA	Substance Abuse Prevention and Treatment Block Grant	Evaluate to analyze the management, implementation, and outcomes of the Substance Abuse Prevention and Treatment Block Grant.

Division	Topic	Description
Strategic Goal 2: Public Health Promotion and Protection, Disease Prevention, and Emergency Preparedness		
ACF	Assets for Independence Act	Evaluate the program to determine the effectiveness of Individual Development Account projects funded by the Assets for Independence Act of 1998 (Public Law 105-285).
ACF	Compassion Capital Fund	Evaluate the Compassion Capital Fund program to assess outcomes and impacts on the organizational capacity of faith-based and community organizations.
ACF	Domestic violence emergency shelters	Evaluate domestic violence emergency shelters in collaboration with the U.S. Department of Justice/National Institute of Justice.
ACF	Long-term transitional living program	Evaluate the program to track long-term gains or losses in housing, educational, employment, and other outcomes for older youth experiencing homelessness and in transitional living residential programs after they are discharged.
ACF	Mentoring Children Of Prisoners (MCP) program	Evaluate the program to compare long-term cognitive, academic, behavioral, and other outcomes of children in MCP programs with those of similar children at risk in concurrent Big Brothers/Big Sisters school mentoring programs.
AHRQ	Prevention	Evaluate the Prevention Portfolio to determine the extent to which the work of the Portfolio contributes to AHRQ's mission and to identify gaps where additional research is needed in preventive healthcare.
ASPE	Disability and health among older adults	Expand our understanding of how obesity affects disability and other health outcomes as people move from late adulthood to older ages.
ASPE	Fall reduction	Pursuing Phase II of a multiyear effort to develop and evaluate a fall reduction intervention for community-dwelling older adults.
ASPE	Obesity reduction and prevention	Encouraging and facilitating future discussions on the issue of marketing foods and beverages to youth and examining the industry's efforts to modify marketing practices to vulnerable populations.
CDC	Community-based interventions for alcohol-impaired driving prevention	Evaluate interventions to decrease alcohol-impaired driving in community settings and its resulting deaths and injuries.
CDC	Effective strategies to reduce motor vehicle injuries among American Indians and Alaska Natives	Evaluate Native American community-based interventions to determine effectiveness for preventing motor vehicle injuries.
CDC	Emergency communication strategic and organizational planning and management	Evaluate the verification of maintenance of 24/7 communication capability to disseminate information to the public.
CDC	Fall prevention strategies among community-dwelling older adults	Evaluate the effectiveness of a comprehensive approach to the prevention of falls among community-dwelling older adults.
CDC	International influenza networks for pandemic influenza preparedness	Evaluate the countries supported by HHS with enhanced influenza surveillance capabilities and the enhancement of influenza virus detection and reporting in these countries.
CDC	National Breast and Cervical Cancer Early Detection Program	Evaluate the National Breast and Cervical Cancer Early Detection Program, focusing on economic analysis.

Division	Topic	Description
Strategic Goal 2: Public Health Promotion and Protection, Disease Prevention, and Emergency Preparedness		
CDC	Prevention of intimate partner violence	Conduct efficacy and effectiveness trials of intervention strategies to prevent intimate partner violence and/or its negative consequences, particularly studies of strategies that have not been well studied.
CDC	Racial and Ethnic Approaches to Community Health program	Evaluate the Racial and Ethnic Approaches to Community Health program to determine the program's effectiveness in reducing health disparities.
CDC	Strategic National Stockpile (SNS) preparedness	Evaluate, through the Program Preparedness Branch, preparedness planning to receive, distribute, and dispense the SNS.
CDC	Terrorism preparedness at U.S. Ports of Entry	Evaluate CDC surveillance of and response to reports of infectious diseases among globally mobile and migrating populations during, and immediately after, travel.
CDC	Using technology to augment effectiveness of parenting programs	Evaluate the effects of information and communication technology (e.g., cell phones, Internet, video conferencing, and Web cameras) on program outcomes, fidelity, enrollment and attrition rates, and cost-effectiveness in reducing child maltreatment when added to a previously demonstrated efficacious or effective parenting program.
CDC	Youth violence prevention through community-level change	Evaluate community-level interventions to reduce youth violence.
FDA	Consumer medication information	Evaluate compliance with Public Law 104-180 requiring that by 2006, 95% of consumers receiving a new prescription will receive useful written information.
FDA	Seafood Hazard Analysis Critical Control Point (HACCP) program	Evaluate the status of domestic and international seafood firms in operating preventive controls under FDA's HACCP program.
NIH	Kidney measure use	Evaluate the extent and conditions under which health care and lab service providers are reporting a measure of kidney function (glomerular filtration rate), to inform development and management of an educational program within the National Kidney Disease Education Program to encourage reporting of this measure.
NIH	Parkinson's disease	Evaluate the Morris K. Udall Parkinson's Disease Centers of Excellence research program to determine whether the centers have achieved program goals.
OD	Physical Fitness Mentoring Program for Children and Youth with Disabilities	Evaluate the "I Can Do It, You Can Do It" Physical Fitness Mentoring Program for Children and Youth with Disabilities.
SAMHSA	Mental Health Services Block Grant	Evaluate the Mental Health Services Block Grant Program to examine system-level activities, outputs, and outcomes associated with supporting the development of comprehensive systems of mental health care within States for adults with serious mental illness and children with serious emotional disturbance.
SAMHSA	Safe Schools/Healthy Students Initiative	Evaluate this initiative to identify practices related to positive systems and student behavior change.
SAMHSA	Strategic Prevention Framework State Incentive Grant Program	Evaluate this program to examine (1) change in State and community systems, particularly improved targeting of, and more appropriate service delivery through, systematic needs assessment, by using the Strategic Prevention Framework; and (2) change in levels of substance use and related risk factors, as well as substance-related problems, among program participants and populations at the State and community levels.

Division	Topic	Description
Strategic Goal 3: Human Services		
ACF and ASPE	Hard-to-Employ Demonstration and Evaluation Project	Evaluate four diverse strategies designed to improve employment and other outcomes such as child well-being for low-income parents and others who face serious barriers to employment.
AoA	Nutrition services and Native American nutrition, supportive, and family caregiver services programs	Evaluate the programs to document overall results, find ways to improve the programs, aid the program planning process, show the programs' contributions to older adult independence, and assess best practices including those programs demonstrating the most effective cost-benefit outcomes and impacts.
AoA	Supportive Services program	Evaluate to determine how, to what extent, and with what results the aging network has implemented the Title III-B Supportive Services program.
ASPE	Abstinence education	Evaluate to assess the implementation and long-term impacts of selected Title V, Section 510 abstinence education programs. Build capacity through the Center for Research and Evaluation in Abstinence Education to conduct sound program evaluations in the abstinence field.
ASPE	Development of supportive communities	Identifying and addressing the existing barriers that prevent faith-based communities from applying for HHS grants.
ASPE	Collaborative initiative to help end chronic homelessness	Evaluate the outcomes and effectiveness of comprehensive integrated community strategies used to deliver stable housing and services to persons experiencing chronic homelessness.
ASPE and ACF	Responsible fatherhood and marriage grants for fathers who are incarcerated and reentering the community	Evaluate the implementation, outcomes, and impact of marriage and corrections strategies in order to identify effective program strategies and determine what kinds of marriage education interventions lead to stronger families and safer communities.
NIH	Cancer Disparities Research Partnerships Program	Evaluate the program to determine whether it is operating as planned and to identify program effects.
OD	Biennial international congress on children, youth, and families with special needs	Evaluate the congress to determine its impact on each participant, as well as the effect of the information from the summit on integrated systems of care in the participating countries.
OD	Young Adult Initiative	Evaluate this initiative to assess how six demonstration States and tribal representatives are attaining State-level administrative infrastructure changes to support transparency across youth and adult services on behalf of young adults (14 to 30 years old) with disabilities.
SAMHSA	Projects for Assistance in Transition from Homelessness program	Evaluate the Projects for Assistance in Transition from Homelessness program.
SAMHSA	Protection and Advocacy for Individuals with Mental Illness Program	Evaluate program inputs, resources, processes, outputs, and outcomes that will be collected from a representative cross-section of stakeholders through surveys and interviews.

Division	Topic	Description
Strategic Goal 4: Scientific Research and Development		
AHRQ	Building Research Infrastructure and Capacity Program (BRIC) and Minority Research Infrastructure Support Program (M-RISP)	Evaluate the effectiveness of the capacity-building BRIC and M-RISP programs.
ASPE	Health information technology (health IT)	Design at least three alternative business case demonstrations and evaluations for the acquisition and use of health IT in long-term care.
ASPE	Health IT	Explore how health information is exchanged with "unaffiliated" post-acute and long-term care providers and other components of the health care delivery continuum (e.g., physician offices, laboratories, pharmacies, and hospitals) that use health IT.
CDC	Amelioration of effects of poverty on children	Evaluate to identify an effective public health intervention to ameliorate the effects of poverty on the health and well-being of children.
CDC	New factors for birth defects	Evaluate the role of at least five new factors for birth defects and developmental disabilities.
CDC	Occupational safety and health	Evaluate progress in reducing agriculture-related workplace illness and injuries, as judged by independent panels of external customers, stakeholders, and experts (based upon relevance and impact of the program).
IHS	Native American Research Centers for Health	Evaluate program administration and progress of grantees.
NIH	Parkinson's disease research	Evaluate the Morris K. Udall Parkinson's Disease Centers of Excellence to determine whether the centers have achieved the program's goals and to examine management of the program.
NIH	Extramural peer review	Evaluate the NIH Extramural Peer Review program to determine whether the current method of determining workload, and consequently staffing requirements, is appropriate and adequate to meet the needs of the NIH Peer Review Program.

Table A-2

Selected Future Program Evaluation Efforts

Division	Topic	Description
Strategic Goal 1: Health Care		
SAMHSA	Addiction Technology Transfer Centers (ATTCs)	Evaluate both the process and impact of the ATTCs, specifically the impact of the ATTCs on increasing and developing the substance use disorder treatment workforce.
SAMHSA	Hepatitis A and B Vaccination Project Performance Monitoring	Evaluate basic clinical information to determine the feasibility and level of success of delivering the combined Hepatitis A and B vaccination (Twinrix) in nontraditional facilities such as substance abuse, methadone, and primary care settings to reach clients infected with or at risk of becoming infected with hepatitis.
SAMHSA	Residential Treatment for Pregnant and Post-Partum Women and their Minor Children	Evaluate the Residential Treatment program for Pregnant and Post-Partum Women and their Minor Children.

Division	Topic	Description
Strategic Goal 2: Public Health Promotion and Protection, Disease Prevention, and Emergency Preparedness		
CDC	Comprehensive Cancer Control Leadership Institutes (CCCLI)	Evaluate CCCLI.
CDC	Evaluation of cooperative agreements	Evaluate Chronic Disease Prevention and Health Promotion Partnership cooperative agreements that were not previously evaluated.
CDC	National Organizational Strategies to Provide Information and Education (with respect to Hematologic Cancers)	Evaluate Hematologic National Organizations.
CDC	Abusive Head Trauma Prevention	Evaluate strategies for the prevention of abusive head trauma.
CDC	Dissemination Research on Fall Prevention: "Stepping On" in a U.S. Community Setting	Evaluate implementation of the program in a community setting; and conduct dissemination evaluation research focusing on participants' outcomes, reach, uptake (adoption), feasibility, fidelity, and acceptability.
CDC	Family and Dyadic Focused Interventions to Prevent Intimate Partner Violence (IPV)	Evaluate to develop, implement, and rigorously test the impact of either a family-based or dyad-based primary prevention strategy on the outcome of physical IPV perpetration and identified mediators with populations at risk for IPV.
CDC	Understanding Risk and Protective Factors for Sexual Violence Perpetration and the Overlap with Bullying Behavior	Evaluate to (1) assess the association between bullying experiences and co-occurring and subsequent sexual violence perpetration and (2) test associations between these forms of violence and potentially modifiable risk and protective factors from multiple levels of social influence (i.e., individual, family, peer, and community factors) to determine the shared and unique risk and protective factors for bullying experiences and sexual violence perpetration.
CDC	Maximizing Protective Factors for Youth Violence	Evaluate to conduct secondary analyses of existing data (not meta-analysis of published studies) to identify potentially modifiable protective factors for youth violence. This research will inform the development of youth violence prevention programs and policies by identifying promising protective factors that reduce the likelihood of violence in the lives of young people.
FDA	Voluntary Cosmetic Registration Program	Evaluate the Voluntary Cosmetic Registration Program to assess the impact of conversion to the online system in capturing current information on use of cosmetic ingredients. FDA uses this information in setting public health priorities as well as allocating resources for regulatory science and enforcement.
SAMHSA	Mental Health Transformation State Incentive Grants (SIGs)	Evaluate the National Outcome Measures data for the SIG States v. data before the beginning of transformation activities and/or v. data from non-SIG States; a collection and analysis of seven GPRA Infrastructure Indicators and a process evaluation of the degree to which the transformed system is recovery oriented.
SAMHSA	Garrett Lee Smith Memorial Suicide Prevention Grants	Evaluate the initiative and its two programs (campus and State/tribal grants) to better understand and improve the initiative.

Division	Topic	Description
Strategic Goal 3: Human Services		
ACF	Developmental Disabilities Programs Independent Evaluation	Evaluate to determine the effectiveness and outreach of developmental disabilities programs.
ACF	Head Start Family and Child Experiences Survey (FACES) 2009	Evaluate to provide longitudinal information on a periodic basis on the characteristics, experiences, and outcomes for children and families served by Head Start; and to observe the relationship among family and program characteristics and outcomes.
AoA	Title III-E, National Family Caregiver Support Program	Evaluate to describe program implementation, and document program results, including identification of areas for program improvement and for provision of program planning guidance.
AoA	Title VII, Long-Term Care Ombudsman Program	Evaluate to examine program efficiency and efficacy to inform program monitoring, improvements, and planning.
ASPE	Abstinence education	Evaluate to (1) assess the implementation and long-term impacts of abstinence education curriculums delivered in middle school settings and (2) assess the implementation and long-term impacts of comprehensive sex education curriculums delivered in middle school settings.
OD	Needs of Youth with Co-Occurring Developmental Disabilities and Emotional/ Substance Abuse Disorders	Evaluate to determine the effectiveness of the interdepartmental initiative to integrate early intervention services for youth with co-occurring developmental disabilities and emotional substance abuse disorders in demonstration States.
SAMHSA	Access to Recovery (ATR) program	Evaluate to review and analyze grantee GPRA data, as well as examine and analyze whether the ATR program is helping States support systems changes to incorporate recovery support services as an integral component of their service delivery systems.
SAMHSA	Family Drug Treatment Courts Program	Evaluate to examine the effectiveness of the Family Drug Treatment Courts Program in four sites that represent two distinct models: a stand-alone family treatment drug court that serves some families who abuse substances involved with the child welfare system and a systemwide approach to serving these families.

Division	Topic	Description
Strategic Goal 4: Scientific Research and Development		
AHRQ	Building Research Infrastructure and Capacity Program (BRIC) and Minority Research Infrastructure Support Program (M-RISP)	Evaluate the effectiveness of the capacity-building BRIC and M-RISP programs.
CDC	Occupational Safety and Health (Construction)	Evaluate progress in reducing construction-related workplace illness and injuries, as judged by independent panels of external customers, stakeholders, and experts (based upon relevance and impact of the program).
CDC	Guide to Community Preventive Services (Community Guide)	Evaluate the level of awareness and use of the Community Guide by State and local public health officers.
CDC	Making National Center for Health Statistics Data Publicly Available	Evaluate the timeliness of health and vital statistics data delivered to the Nation's health decisionmakers.
NIH	Infectious Disease Models	Evaluate the Models of Infectious Disease Agent Study to determine whether the program is operating as planned and areas for program improvement.

APPENDIX B

Performance Indicators

Performance Indicators—Supplemental Information

		Most Recent Result	FY 2012[20] Target	Source
Strategic Goal 1: Health Care				
Strategic Objective 1.1 **Broaden health insurance and long-term care coverage.**				
1.1.1	Implement the Medicare Prescription Drug Benefit – Increase the percentage of Medicare beneficiaries with Prescription Drug Coverage from Part D or other sources.	90% (FY 2007)	93%	Management Information Integrity Repository (MIIR) and updates from other external data sources
1.1.2	Reduce the percentage of improper payments made under the Medicare FFS program.	4.4% (FY 2006)	(Available FY 2009)	CMS Comprehensive Error Rate Testing Program
Strategic Objective 1.2 **Increase health care service availability and accessibility.**				
1.2.1	Increase the number of persons (all ages) with access to a source of ongoing care.	87% (FY 2005)	96%	National Health Interview Survey
1.2.2	Expand access to health screenings for American Indians and Alaskan Natives: a) Increase the proportion of patients with diagnosed diabetes who receive an annual retinal examination; and b) Increase the proportion of eligible patients who have had appropriate colorectal cancer screening.	a) 49%; and b) 22%. (FY 2006)	a) 75%; and b) 50%. (FY 2010)	IHS Clinical Reporting System
1.2.3	Increase the number of patients served by Health Centers.	14.1 million (FY 2005)	16.4 million	Bureau of Primary Health Care Uniform Data System
1.2.4	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.	72% (FY 2005)	5 percentage points above CDC data on national prevalence	Ryan White HIV/AIDS Program Data; CDC HIV/AIDS Surveillance Report
1.2.5	Increase the number of client admissions to substance abuse treatment programs receiving public funding.	1,875,026 (FY 2004)	2,005,220	Treatment Episode Data Set

20 FY 2012 Target, unless otherwise indicated.

		Most Recent Result	FY 2012[20] Target	Source
Strategic Goal 1: Health Care				
Strategic Objective 1.3 **Improve health care quality, safety, cost, and value.**				
1.3.1	Increase physician adoption of electronic health records.	10% (FY 2005)	40%	National Ambulatory Medical Care Survey
1.3.2	Decrease the prevalence of restraints in nursing homes.	6.1% (FY 2006)	5.8%	Minimum Data Set-Quality Measure
1.3.3	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.	0 States (FY 2007)	12 States	State Reports include, but are not limited to: State Quality Improvement strategies, External Quality Review Organization Reports, and Home- and Community-Based Services Waiver Quality Assessment reports
Strategic Objective 1.4 **Recruit, develop, and retain a competent health care workforce.**				
1.4.1	Increase the number of Commissioned Corps response teams formed.	10 teams (FY 2006)	36 teams	OSG/Office of Force Readiness and Deployment
1.4.2	Increase the number of Commissioned Corps officers.	5,906 (FY 2006)	6,600	Office of Public Health and Science, monthly billing amounts

		Most Recent Result	FY 2012 Target	Source
Strategic Goal 2: Public Health Promotion and Protection, Disease Prevention, and Emergency Preparedness				
Strategic Objective 2.1 Prevent the spread of infectious diseases.				
2.1.1	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).	a) DTaP: 86%; b) Polio: 92%; c) MMR: 92%; d) Hepatitis B: 93%; e) Hib: 94%; f) Varicella: 88%; and g) PCV7: 83%. (FY 2005)	At least 90%	National Immunization Survey
2.1.2	Increase the proportion of people with HIV diagnosed before progression to AIDS.	76.5% (FY 2005)	81%	HIV/AIDS Reporting System
2.1.3	Reduce the incidence of infection with key foodborne pathogens: a) Campylobacter; b) Escherichia coli O157:H7; c) Listeria monocytogenes; and d) Salmonella species.	Cases/100,000: a) 12.72; b) 1.06; c) 0.30; and d) 14.55. (FY 2005)	Cases/100,000: a) 12.30; b) 1.00; c) 0.23; and d) 6.80.	FoodNet (The Foodborne Diseases Active Surveillance Network) Data
2.1.4	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.	a) 59.6%; and b) 25.3%. (FY 2005)	a) 90%; and b) 60%.	National Health Interview Survey
Strategic Objective 2.2 Protect the public against injuries and environmental threats.				
2.2.1	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.	a) 4.4/100 FTE[21]; and b) 3.2/100,000 FTE. (FY 2006)	a) 4.2/100 FTE; and b) 2.8/100,000 FTE.	a) National Electronic Injury Surveillance System; and b) Census of Fatal Occupational Injuries special research file provided to National Institute of Occupational Safety and Health by Bureau of Labor Statistics.

21 FTE = full-time equivalent employee, and one FTE = 2,000 hours worked (average hours worked by a full-time employee in a year).

		Most Recent Result	FY 2012 Target	Source
Strategic Goal 2: Public Health Promotion and Protection, Disease Prevention, and Emergency Preparedness				
Strategic Objective 2.3 Promote and encourage preventive health care, including mental health, lifelong healthy behaviors, and recovery.				
2.3.1	Reduce complications of diabetes among American Indians and Alaska Natives by increasing the proportion of patients with diagnosed diabetes who have achieved blood pressure control (<130/80).	37% (FY 2006)	50% (FY 2010)	IHS Clinical Reporting System
2.3.2	Increase the proportion of women aged 40 years and older who have received a mammogram within the preceding 2 years.	74.6% (CY 2005)	77%	Behavioral Risk Factor Surveillance System
2.3.3	Reduce 30-day use of illicit substances (age 12 and older).	7.9% (FY 2005)	5.8%	National Survey on Drug Use and Health
2.3.4	Reduce the number of suicide deaths.	32,439 (FY 2004)	30,584	National Vital Statistics Report
Strategic Objective 2.4 Prepare for and respond to natural and manmade disasters.				
2.4.1	Increase the percentage of State public health agencies prepared to use materiel contained in the Strategic National Stockpile (SNS).	70% (FY 2006)	90%	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*
2.4.2	Increase the number of States and territories that include persons with disabilities in emergency management plans and responses.	6 (FY 2006)	55	Annual Assessment Report of State Emergency Management Plans and U.S. Department of Homeland Security Annual Report to the President.

22 FTE = full-time equivalent employee, and one FTE = 2,000 hours worked (average hours worked by a full-time employee in a year).

		Most Recent Result	FY 2012 Target	Source
Strategic Goal 3: Human Services				
Strategic Objective 3.1 Promote the economic independence and social well-being of individuals and families across the lifespan.				
3.1.1	Increase the percentage of adult TANF recipients who become newly employed.	34.3% (FY 2005)	39%	National Directory of New Hires
3.1.2	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.	11.27% (FY 2005)	11.34%	Program Performance Reports of State Councils on Developmental Disabilities
3.1.3	Increase the child support collection rate for current support orders.	60% (FY 2005)	63%	Office of Child Support Enforcement Form 157
Strategic Objective 3.2 Protect the safety and foster the well-being of children and youth.				
3.2.1	Increase the adoption rate for children involved in the Child Welfare System.	10.06% (July 2007)	10.40%	Adoption and Foster Care Analysis Reporting System
3.2.2	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.	a) 52%; and b) 84.6%. a) (FY 2005) b) (FY 2006)	66%; and 86%.	National Reporting System
3.2.3	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.	69.3% (FY 2006)	70%	Delinquency Survey
Strategic Objective 3.3 Encourage the development of strong, healthy, and supportive communities.				
3.3.1	Increase the number of children living in married couple households as a percentage of all children living in households.	69% (CY 2005)	72%	Census Survey Data
Strategic Objective 3.4 Address the needs, strengths, and abilities of vulnerable populations.				
3.4.1	Increase the number of older persons with severe disabilities who receive home-delivered meals.	313,362 (FY 2005)	500,000	National Aging Program Information System State Program Reports National Surveys
3.4.2	Increase the percentage of refugees entering employment through refugee employment services funded by ACF.	53.49% (FY 2005)	60%	Quarterly Performance Report (Form ORR-6)

		Most Recent Result	FY 2012 Target	Source
Strategic Goal 4: Scientific Research and Development				
Strategic Objective 4.1 Strengthen the pool of qualified health and behavioral science researchers.				
4.1.1	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	a) 13 percentage points; and b) 13 percentage points. (FY 2006)	a) 12+ percentage points; and b) 12+ percentage points.	Outcome Evaluation of NIH National Research Service Award Postdoctoral Training Program
Strategic Objective 4.2 Increase basic scientific knowledge to improve human health and human development.				
4.2.1	Develop and apply clinically one new imaging technique to enable tracking the mobility of stem cells within cardiovascular tissues.	Researchers in the NIH intramural program have developed probes that are compatible with optical microscopy techniques developed by intramural scientists. (FY 2006)	Develop one new imaging technique that is able to be clinically applied.	Study Data
4.2.2	Identify at least one clinical intervention that will delay the progression or onset of Alzheimer's disease (AD), or prevent it.	Nearly 1,000 new late-onset AD families have been identified and recruited to the AD Genetics Initiative. (FY 2006)	Identify the next generation of compounds for testing in pilot clinical trials.	Study Data
4.2.3	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.	The prototype pattern recognition algorithm has been designed and trained to recognize anomalies in the pilot study of Brain MRS scans. (Nonpublished results, spring 2007)	Apply, in conjunction with a CRADA partner, a pattern recognition algorithm to identify early biomarkers of brain disease to other disease endpoints in clinical applications such as those used to identify breast cancer markers.	Annual NCTR Research Accomplishments and Plans document located at: http://www.fda.gov/nctr/science/research_index.htm

		Most Recent Result	FY 2012 Target	Source
Strategic Goal 4: Scientific Research and Development				
Strategic Objective 4.3 Conduct and oversee applied research to improve health and well-being.				
4.3.1	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.	Initial findings were made public at the annual American Diabetes Association meeting in June 2006. (FY 2006)	Complete clinical trials, and make results available.	Study Data
Strategic Objective 4.4 Communicate and transfer research results into clinical, public health, and human service practice.				
4.4.1	Increase the number of AoA-supported community-based sites that use evidence-based disease and disability prevention programs.	27 sites (FY 2005)	136 sites	Evidence-Based Disease Prevention discretionary grant semiannual reports
4.4.2	Reduce the disparity between African-American infants and White infants in back sleeping by 50% to reduce the risk of Sudden Infant Death Syndrome (SIDS).	The SIDS rate for African-American infants is two times greater than that of White infants. (FY 2003)	Reduce disparity by 50%.	Study Data
4.4.3	Reduce the financial cost (or burden) of upper GI hospital admissions by implementing known research findings	$93.46 per U.S. resident ages 65 to 85. (FY 2006)	10% reduction	Healthcare Cost and Utilization Project

APPENDIX C

Performance Plan Linkage

Performance Plan Linkage

HHS Strategic Plan, Annual Plan, and Annual Performance Budgets

HHS manages hundreds of programs that aim to improve health status, increase access to health services, and create opportunities for disadvantaged individuals to work and lead productive lives. HHS programs reach all Americans by providing health and social services, protecting public health, and funding biomedical research. The *Strategic Plan* defines the goals and objectives of the Department and is driven by the Department's mission 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. HHS also uses strategic planning, annual performance planning, and the annual budget process to identify policy and program priorities. The *Strategic Plan*, along with the Secretary's 500-Day Plan, the Secretary's Priorities,[23] and the President's Management Agenda,[xlii] provide the overarching framework for the Department's operating and staff divisions to use on an annual basis to create an annual performance plan.

The HHS Annual Plan is the primary mechanism for implementing the *Strategic Plan*. The two planning documents are intertwined. The *Strategic Plan* sets broad, long-term objectives for the Department and describes principal implementation strategies for achieving the strategic objectives. The Annual Performance Plan sets specific annual goals for HHS programs and initiatives and relates these goals to the strategies and long-term objectives in the *Strategic Plan*. In so doing, the link between annual program activities and goals and the *Strategic Plan* is established.

To gauge program effectiveness, HHS uses performance indicators as a basis for comparing program results with established program performance goals. Each year, HHS tracks the performance indicators from this *Strategic Plan* in the HHS Annual Plan, which illustrates the Department's progress in accomplishing its priorities and goals. HHS performance budgets annually track a broader set of performance indicators to measure progress on all Departmental programs and activities. The HHS performance budgets present the resource needs of HHS programs and identify the results that Americans can expect from their investment in these programs. The performance budgets state planned goals based on funding levels and also report on past achievements of all HHS programs.[xliii]

At the close of each fiscal year, HHS produces a Performance and Accountability Report (PAR), which incorporates performance results with audited financial statements for the year. The PAR highlights illustrative programs to report on HHS performance. Together, the Annual Plan and the PAR constitute an annual planning and reporting process for HHS programs. The performance indicators in the *Strategic Plan* will be reported on in the PAR so that progress in achieving goals is measured on an annual basis.

Statutory Requirements: GPRA, OMB Circular No. A-11

***The Government Performance and Results Act of 1993* (GPRA)** provides the statutory framework for a recurring cycle of reporting, planning, and execution, requiring agencies to craft

5-year strategic plans, updated every 3 years; annual performance plans, or annual performance budgets; and annual program performance reports.

OMB Circular No. A-11, Section 210 (2006), *Preparing and Submitting a Strategic Plan* indicates that agencies should include in their strategic plans a description of the relationship between annual program performance goals and the agency's strategic goal framework, including a description of how the Program Assessment Rating Tool (PART) process contributes to this effort.

A Culture of Excellence: Comprehensive Performance Management System for Employees

Only by maintaining a strong "culture of excellence" can HHS continue to achieve the exceptional results that the public has come to expect. This approach links the work of every employee to the ultimate outcomes of the Department and stresses each individual's accountability for the results of HHS as a whole. Expectations must be transparent; assessments of performance must be meaningful; and

23 The Introduction/Executive Summary *In the Spotlight* section contains additional information about the Secretary's 500-Day Plan and priorities.

every employee must understand how his or her own efforts contribute to accomplishing the HHS mission. HHS has taken major steps toward implementing a comprehensive performance management system covering every one of its employees, including updating the Senior Executive Service and Organizational Performance Management System and implementing the Performance Management Appraisal System at all operating divisions.

Senior Executive Service and Organizational Performance Management System

HHS has an updated Senior Executive Service (SES) Organizational Performance Management System. The system includes the Department's first detailed description of its organizational assessment process and is designed to produce accountability for results for every one of HHS's senior executives. The SES system operates under a straightforward set of guiding principles: True excellence is rewarded; mediocre performance carries real consequences; and poor performers are removed from the SES. Most important, evidence of measurable, citizen-centered outcomes is valued over bureaucratic process and "time served."

As the key elements of SES performance plans are cascaded to the plans of all non-SES employees, this new comprehensive performance system will ensure that expectations throughout the entire agency are consistently aligned with the HHS mission and focused on achieving results. Ultimately, the system places the greatest emphasis where it belongs: on achieving results that benefit the American people.

Performance Management Appraisal Program

The HHS Performance Management Appraisal Program (PMAP) establishes a new performance management system that focuses on the connections between an individual's day-to-day work and the overarching goals of the Department. Covering all non-SES HHS employees, PMAP will provide staff with a clearer sense of how their own success contributes to that of the Department as a whole. With four performance levels—exceptional, fully successful, minimally successful, and unsatisfactory—the new system improves the transparency of the appraisal process and helps ensure that distinctions between high and low performers will be meaningful and consistent across the Department. As of December 2006, PMAP covers every non-SES employee at HHS.

APPENDIX D

Information Technology

The transformation of how technological and data access work is performed in the Department is due in part to rapid changes in computer technology. The technology industry has evolved from word processors to microprocessors, from collecting data to warehousing data, and from information management to knowledge management. In order to leverage these advances, HHS's business model must be supported by its technical model. Both must become fully synchronized to realize the strategic goals and objectives of HHS.

Over the past several years, each HHS division has developed its own means and methods of dealing with computer technology, resulting in a network of separate systems that have limited capacity to interact with each other in a seamless fashion. HHS has now implemented an Enterprise Architecture program that addresses planning from an enterprise perspective to ensure that the allocation of resources is aligned with the effort to realize the HHS strategic goals and objectives. Within this enterprise planning activity, information resources and technology are not only aligned in support of the HHS strategies, but also focus on the facilitation of interoperability, data sharing, and overall efficiency and effectiveness across the Department and with HHS's external partners.

This appendix offers a broad overview of the initiatives that the Department is currently undertaking, and some of the innovations and trends that are planned.

Initiatives

Two basic pieces of legislation have framed how the Federal Government operates and provides services to the public. The first is the E-Government Act of 2002 (Public Law 107-347), which seeks to enhance management and promotion of business through the Internet, reduce a paper-based environment, and increase citizen services and access to Government information. The second piece of legislation is the Federal Information Security Management Act of 2002 (Public Law 107-347), which provides for a comprehensive framework to ensure that access to information is kept safe and secure.

This legislation creates a trend in the Government that requires a higher level of attention to security than ever before. The drive for greater efficiency in information technology spending, combined with an ever-increasing need to share networks, services and support, and information, has resulted in both placing more business transactions online and creating a need for increased attention on the Department's security.

Secure One HHS

On the basis of the best practices of the Government Accountability Office and the standards and guidance provided by the National Institute of Standards and Technology, HHS has set up an overarching information technology security program called *Secure One HHS*. The emphasis of *Secure One* is to create strong governance with clearly defined roles, responsibilities, and security expertise. Established at the headquarters level, *Secure One* seeks to achieve a consistent security baseline across operating divisions by supporting universal information technology security requirements. The *Secure One* program is driven by close coordination and collaboration with each operating division to ensure that any needs and expectations are identified and addressed.

Infrastructure

Cost-effectiveness in technology represents responsible stewardship over taxpayer dollars as well as responsible and effective management of human resources. Over the years, as divisions developed their

own methods of managing computer technology, the basic infrastructure for a unified Departmentwide computer system was overlooked. To unify these disparate systems, reduce duplication of effort, and stabilize the technical environment, the Department has initiated several strategies for improving the technological infrastructure.

IT Consolidation. This strategy employs the sharing and reuse of common, standards-based materials and programs that support the business of computer technology. An example of this strategy is using the same physical systems (networks, servers, and help desks).

Software Standardization. A preliminary inventory of software packages used across the Department revealed that more than 12,000 unique types of software had been loaded on computers. A major initiative is underway to streamline the amount and type of software loaded on employee machines. The standardization process ensures that security is not compromised and that all software is up to date.

Health Information Technology

The Department is committed to the principles, objectives, and strategies of the Office of the National Coordinator for Health Information Technology (ONC), in the Office of the Secretary. This major initiative is being supported by the Office of the Chief Information Officer, and is discussed in depth in *In the Spotlight: Advancing the Development and Use of Health Information Technology*. The Office of the Chief Information Officer will coordinate consultation for ONC in the areas of standards, best practices, reviews, and support.

HHS Data Council

The HHS Data Council advises the Secretary on data policy and serves as a forum for coordination and consideration of those issues. The Council also coordinates the Department's data collection and analysis activities and ensures effective long-range planning for surveys and other investments in major data collection. The Council also serves as the Department's focal point for data standards and national health information issues.

Confidentiality and Data Access Committee

This group provides a forum for staff members of Federal statistical agencies who work on confidentiality and data access topics.

Web Services

Citizens, employees, and stakeholders now use the Internet for most of their information needs. The Internet has become the standard for conducting business transactions, finding key information, and engaging in knowledge sharing with others of like interests. The Department recognizes the need to have the most up-to-date strategies involving the Internet, from structure to design, and from functionality to accessibility. Several initiatives are underway to ensure that the rich repository of information and knowledge within HHS is easily accessible and effectively displayed, and that the format of Web pages is usable to the average visitor.

Governance. The HHS Department Web site exists to empower citizens, its business and service partners, and its employees by providing information, work processes, services, and opportunities to be involved in their government effectively, efficiently, and in a timely manner. Therefore, they can improve their lives, solve their problems, and accomplish their objectives. To that end, the Department is developing Web governance principles, strategies, and recommendations so that HHS's Web presence will be more consistent and coherent across divisions. HHS Web governance principles will maximize the creative use of people, policy, and processes to manage short- and long-range goals, mitigate ambiguity, and resolve conflicting cross-Department needs and priorities. They will provide a framework for establishing clear Web management responsibilities, identifying and allocating necessary resources, promoting Departmentwide standards for best practices, and providing recognition and support for the Department's Web community.

Usability. On the basis of sound research, the Department has developed a cutting-edge guide to Web design and usability. Produced by HHS and the General Services Administration, this guide is an invaluable tool for Web developers, Web designers,

and Web site managers. The guide was created to deliver better and more usable health and human service sites for the Department. HHS is mandated to provide clear information in an efficient and effective manner to patients, health professionals, researchers, and the public. Translating the latest Web design research into a practical, easy-to-use format is essential to the effective design of the numerous Department Web sites. In addition, the Department has set standards and criteria for all Web sites to be in full compliance with Section 508 of the Rehabilitation Act of 1973 (29 USC 794d), as amended, which requires the Internet to be accessible to individuals with disabilities.

Innovations and Future Trends

E-Government

E-Government is the President's goal of utilizing technology to improve how the Federal Government serves citizens, businesses, and agencies alike. Federal employees are serving citizens, businesses, and local communities via E-Government. E-Government uses improved Internet-based technology to make it easy for citizens and businesses to interact with the Government, save taxpayer dollars, and streamline citizen-to-government communications. E-Government uses technology to its fullest to provide services and information that are centered on citizen groups.

The Department will continue its investment in E-Government initiatives by using standards-based Web services. This means that reliable and consistent methodologies will be used to create and support Web and Internet services. The Department uses Internet Web sites, an Intranet Web site, and an internal HHS Web portal. These sites have provided timely and important communications to stakeholders and the public.

In the coming months, HHS will launch a software program, known as Content Management Solution, which will reduce the time and effort to modify Web pages and update information. This software will make Internet maintenance more streamlined and convenient for contributors.

Integrated Planning

HHS is adopting a strategy, the *Capital Planning and Investment Control* (CPIC) program, in which investments in technology will be based on strategic goals and objectives. For each strategy, the questions will be posed: "How will technology support this? How much is needed, how will it be measured, how will it perform?"

In this model, the investments in technology are treated as a *portfolio,* with information available on measurement, results, and return on investment. This approach will allow senior managers to access up-to-date information on program performance from a top-to-bottom view of the Department. Information technology portfolio management is implemented within the context of the HHS information technology CPIC program, which is strongly integrated with the HHS Enterprise Architecture program to ensure that the information technology investments proposed for portfolio inclusion are effectively aligned in support of the HHS strategic goals and objectives.

In addition, the model includes a framework for a centralized information management system. This will mean that the multiple requests for information that HHS receives can be handled centrally without duplication or redundancy. The model also promotes sharing and reusing data across HHS once they are collected in the centralized database.

The CPIC program will fulfill several general requirements. Strategic planning and performance management will be integrated with other information technology processes. The CPIC program will be able to permeate the entire Department, and accommodate new data and legislative requirements as they arise. Data reusability will solve the problem of repeated requests for information that is individually managed in a time- consuming process. The CPIC program will support the right information collected at the right time so that it can be formatted and presented to meet demands.

Information technology is sometimes seen as an enabler of the mission and strategic plan, rather than a direct contributor. The CPIC program realizes the need to give insight to how information technology is leading

business and mission outcomes, through objectives and measures. This insight can help foster a culture of accountability and increase management's effectiveness.

Knowledge Management

HHS is a knowledge-intensive organization and faces significant opportunities and challenges in generating value from its intellectual and knowledge-based assets. Knowledge Management is a way of doing business that capitalizes on the knowledge of an organization and its individual employees.

Knowledge Management provides the processes and structures to create, capture, analyze, and act on information. It highlights both the conduits to knowledge, as well as the bottlenecks. The emphasis in Knowledge Management is on human know-how and how to enable it to bring maximum return for an organization.

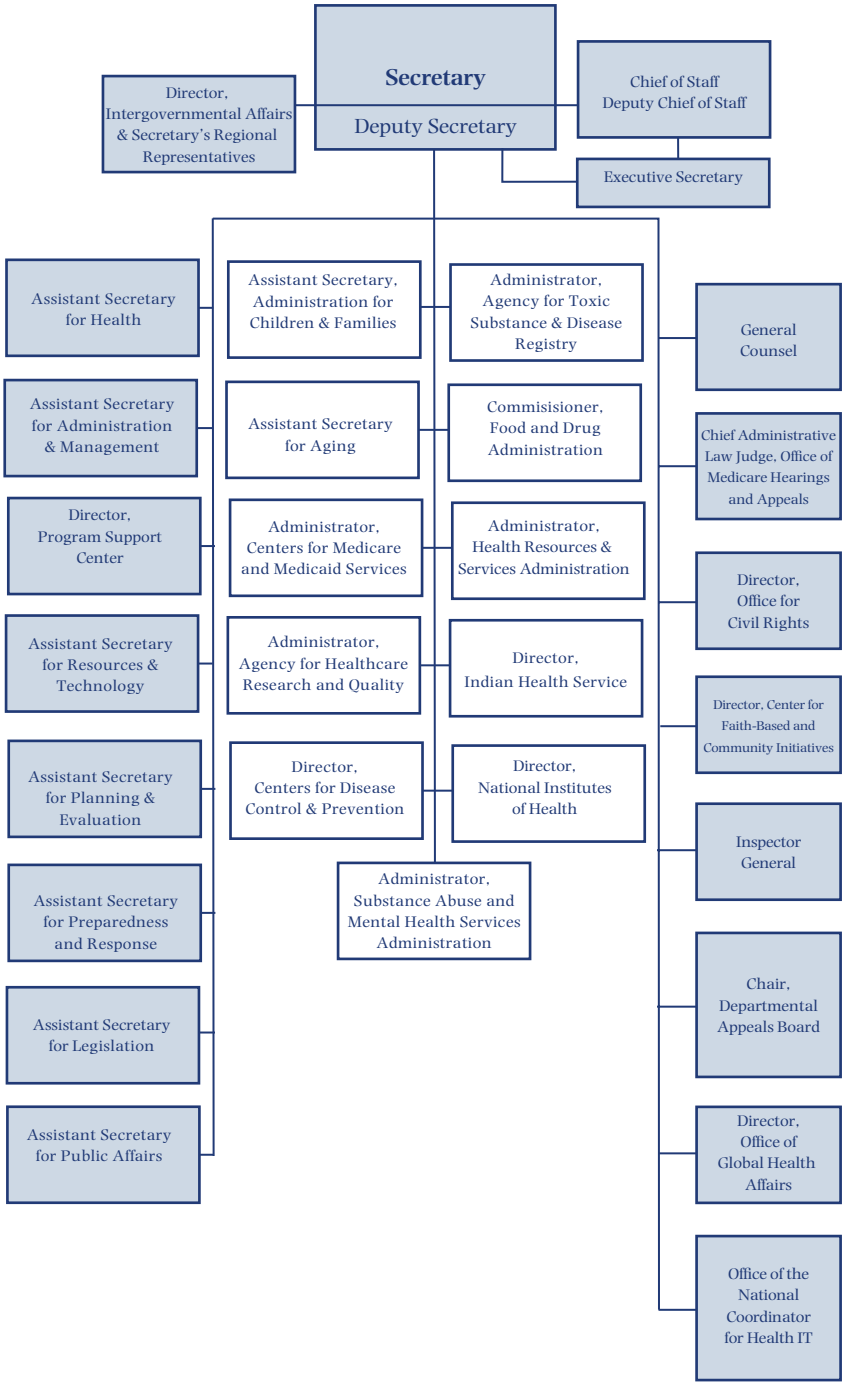
Information technology is critical to facilitate knowledge sharing and can be seen as the vehicle for effective Knowledge Management. Getting the right knowledge to the right person for the right task at the right time is the goal. Whether to improve organizational efficiency, or embrace innovation, Knowledge Management efforts and initiatives add great value to an organization. Knowledge Management:

- Facilitates better, more informed decisions;
- Contributes to the intellectual capital of an organization;
- Encourages the free flow of ideas that leads to insight and innovation;
- Eliminates redundant processes, streamlines operations, and enhances employee retention rates;
- Improves customer service and efficiency; and
- Can lead to greater productivity.

HHS is charged with communicating information to citizens, customers, employees, and Federal, State, and local governments. The management and sharing of knowledge within HHS is of paramount importance to its stakeholders. The collaborative nature of activities depends on advancing the understanding of this innovative business model. HHS is committed to implementing this innovative business process throughout the Department.

APPENDIX E

HHS Organizational Chart


Secretary
Deputy Secretary
Director, Intergovernmental Affairs & Secretary's Regional Representatives
Chief of Staff
Deputy Chief of Staff
Executive Secretary
Assistant Secretary for Health
Assistant Secretary for Administration & Management
Director, Program Support Center
Assistant Secretary for Resources & Technology
Assistant Secretary for Planning & Evaluation
Assistant Secretary for Preparedness and Response
Assistant Secretary for Legislation
Assistant Secretary for Public Affairs
Assistant Secretary, Administration for Children & Families
Assistant Secretary for Aging
Administrator, Centers for Medicare and Medicaid Services
Administrator, Agency for Healthcare Research and Quality
Director, Centers for Disease Control & Prevention
Administrator, Substance Abuse and Mental Health Services Administration
Administrator, Agency for Toxic Substance & Disease Registry
Commisisioner, Food and Drug Administration
Administrator, Health Resources & Services Administration
Director, Indian Health Service
Director, National Institutes of Health
General Counsel
Chief Administrative Law Judge, Office of Medicare Hearings and Appeals
Director, Office for Civil Rights
Director, Center for Faith-Based and Community Initiatives
Inspector General
Chair, Departmental Appeals Board
Director, Office of Global Health Affairs
Office of the National Coordinator for Health IT

APPENDIX F

HHS Operating and Staff Divisions and Their Functions

HHS works to accomplish its mission through the individual and collaborative efforts of the operating divisions and staff divisions within the Office of the Secretary (OS). The primary goal of OS is to provide leadership, direction, and policy and management guidance to the Department.

Operating Divisions:

Administration for Children and Families (ACF)

http://www.acf.dhhs.gov/

To promote the economic and social well-being of families, children, individuals, and communities. ACF grant programs lead the Nation in strengthening economic independence and productivity and enhancing quality of life for people across the lifespan.

Agency for Healthcare Research and Quality (AHRQ)

http://www.ahrq.gov

To support, conduct, and disseminate research that improves access to care and the outcomes, quality, cost, and utilization of health care services. Information from AHRQ's research on outcomes, quality, costs, use, and access helps people make more informed decisions and improves the value of the health care services they receive.

Administration on Aging (AoA)

http://www.aoa.gov

To promote the dignity and independence of older people, and to help society prepare for an aging population. AoA serves as the primary Federal focal point and advocacy agent for older Americans through a network of State and area agencies on aging and grants to States, tribal organizations, and other community service providers.

Agency for Toxic Substances and Disease Registry (ATSDR)

http://www.atsdr.cdc.gov

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. ATSDR efforts prevent exposure and adverse human health effects and diminished quality of life associated with exposure to hazardous substances.

Centers for Disease Control and Prevention (CDC)

http://www.cdc.gov

To promote health and quality of life by preventing and controlling disease, injury, and disability. CDC strengthens existing public health infrastructure while working with partners throughout the Nation and the world.

Centers for Medicare & Medicaid Services (CMS)

http://www.cms.hhs.gov

To ensure effective, up-to-date health care coverage and to promote quality care for beneficiaries. CMS serves as the primary source of health care insurance coverage for a large population of medically vulnerable individuals and acts as a catalyst for enormous changes in the availability and quality of health care for all Americans.

Food and Drug Administration (FDA)

http://www.fda.gov

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. FDA advances the public health by helping to speed innovations to market that make medicines and food more effective, safer, and more affordable, and assisting the public in getting the accurate, science-based information they need to use medicines and foods to improve their health.

Health Resources and Services Administration (HRSA)

http://www.hrsa.gov

To provide the national leadership, program resources, and services needed to improve access to culturally competent, quality health care. HRSA focuses on uninsured, underserved, and special needs populations in its goals and program activities.

Indian Health Service (IHS)

http://www.ihs.gov

To raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level. IHS provides comprehensive health services for AI/AN people, with opportunity for maximum tribal involvement in developing and managing programs to improve their health status and overall quality of life.

National Institutes of Health (NIH)

http://www.nih.gov

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. NIH, through its 27 institutes and centers, supports and conducts research, domestically and abroad, into the causes, diagnosis, treatment, control, and prevention of diseases and promotes the acquisition and dissemination of medical knowledge to health professionals and the public.

Substance Abuse and Mental Health Services Administration (SAMHSA)

http://www.samhsa.gov

To build resilience and facilitate recovery for people with or at risk for substance abuse and mental illness. SAMHSA supports States and communities in building resilience and facilitating recovery through grant programs, policy guidance, information dissemination, data collection and reporting, evaluation, and technical assistance.

Office of the Secretary:
Staff Divisions:

Assistant Secretary for Administration and Management (ASAM)

http://www.hhs.gov/asam

To help bring about improvements and effectiveness that can be achieved by structuring HHS as a united department, in support of the Secretary's goals and the President's Management Agenda. ASAM advises the Secretary on all aspects of administration and human resource management.

Assistant Secretary for Health (ASH)

http://www.hhs.gov/ash

To provide senior professional leadership across HHS on crosscutting, population-based public health and clinical preventive services. The Office of Public Health and Science is under the direction of the ASH, who serves as the Secretary's primary advisor on matters involving the Nation's public health and oversees the Commissioned Corps of the United States Public Health Service through the Office of the Surgeon General.

Assistant Secretary for Legislation (ASL)

http://www.hhs.gov/asl

To advise the Secretary and the Department on congressional legislation and to facilitate communication between the Department and the U.S. Congress. ASL informs the Congress of Departmental priorities, actions, grants, and contracts.

Assistant Secretary for Planning and Evaluation (ASPE)

http://aspe.hhs.gov/

To provide advice and support to the Secretary on the development and analysis of *crosscutting, population-based health and human service policies.* ASPE is responsible for major activities in policy coordination, legislation development, strategic planning, policy research, evaluation, and economic analysis.

Assistant Secretary for Public Affairs (ASPA)

http://www.hhs.gov/news

To serve as the Secretary's principal counsel on public affairs matters and to provide centralized leadership and guidance for public affairs activities within HHS. ASPA coordinates media relations and public service information campaigns throughout HHS and manages the Freedom of Information process for the Department.

Assistant Secretary for Preparedness and Response (ASPR)

http://www.hhs.gov/aspr/

To serve as the Secretary's principal advisory staff on matters related to bioterrorism and other public health emergencies. ASPR directs the Department's emergency response activities and coordinates interagency activities related to emergency preparedness and the protection of the civilian population.

Assistant Secretary for Resources and Technology (ASRT)

http://www.hhs.gov/asrt

To provide advice and guidance to the Secretary on budget, financial management, and information technology and to provide for the direction and coordination of these activities throughout the Department. ASRT provides oversight of the administrative and financial organizations and activities of the Department, including production of the Department's financial statements and the annual performance plan and report under the Government Performance and Results Act of 1993 (Public Law 103-62).

Center for Faith-Based and Community Initiatives (CFBCI)

http://www.hhs.gov/fbci

To create an environment within HHS that welcomes the participation of faith-based and community-based organizations as valued and essential partners assisting Americans in need. CFBCI leads the Department's efforts to better utilize faith-based and community-based organizations in providing effective human services.

Departmental Appeals Board (DAB)

http://www.hhs.gov/dab

To provide the best possible dispute resolution services for the people who appear before the board, those who rely on the decisions, and the public. DAB provides prompt, fair, and impartial dispute resolution services to parties in many different kinds of disputes involving components of the Department. DAB encourages the use of mediation and other forms of alternative dispute resolution.

Office for Civil Rights (OCR)

http://www.hhs.gov/ocr

To ensure that people have equal access to, and opportunity to participate in and receive services from all HHS programs without facing unlawful discrimination, and the protection of the privacy of their identifiable health information while ensuring access to care. Through prevention and elimination of unlawful discrimination, OCR helps HHS carry out its overall mission of improving the health and well-being of all people, including those affected by its many programs.

Office on Disability (OD)

http://www.hhs.gov/od

To oversee the coordination, development, and implementation of programs and special initiatives within HHS that impact people with disabilities. OD serves as focus of advocacy activities undertaken on behalf of persons with disabilities.

Office of the General Counsel (OGC)

http://www.hhs.gov/ogc

To advance the Department's goal of protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves. OGC is the legal team for the Department, providing quality representation and legal advice on a wide range of highly visible national issues. OGC supports the development and implementation of the Department's programs by providing the highest quality legal services to the Secretary and the Department's divisions.

Office of Global Health Affairs (OGHA)

http://www.hhs.gov/ogha

To promote the health of the world's population by advancing HHS global strategies and partnerships, thus serving the health of the people of the United States. OGHA represents HHS to other governments, other Federal departments and agencies, international organizations, and the private sector on international and refugee health issues.

Office of Inspector General (OIG)

http://oig.hhs.gov

To protect the integrity of HHS programs, as well as the health and welfare of the beneficiaries of those programs. By conducting independent and objective audits, evaluations, and investigations, OIG provides timely, useful, and reliable information and advice to Department officials, the Administration, the U.S. Congress, and the public.

Office of Intergovernmental Affairs (IGA)

http://www.hhs.gov/iga

To facilitate communication regarding HHS initiatives as they relate to State, local, and tribal governments. IGA is the Department's liaison to State, local, and tribal governments, and the national organizations that represent them. IGA represents the perspectives

of these HHS partners in the Federal policymaking process and helps communicate the Federal perspective to them. IGA's Office of Tribal Affairs serves as the first point of contact for tribes and tribal organizations working with HHS and assists tribes in navigating policies and requirements for HHS programs and services.

Office of Medicare Hearings and Appeals (OMHA)

http://www.hhs.gov/omha

To administer the nationwide hearings and appeals for the Medicare program, and to ensure that the American people have equal access and opportunity to appeal and can exercise their rights for health care quality and access. OMHA, under direct delegation from the Secretary, administers nationwide hearings for the Medicare program. The Administrative Law Judges within OMHA conduct impartial hearings and issue decisions on behalf of the Secretary on claims determination appeals involving Parts A, B, C, and D of Medicare, and on Medicare entitlement and eligibility appeals.

Office of the National Coordinator for Health Information Technology (ONC)

http://www.hhs.gov/healthit

To provide leadership for the development and nationwide implementation of interoperable health information technology to improve the quality and efficiency of health care and the ability of consumers to manage their care and safety. The National Coordinator for Health Information Technology is the Secretary's principal advisor on the development, application, and use of health information technology in both the public and private health care sectors that will reduce medical errors, improve quality, and produce greater value for health care expenditures.

Program Support Center (PSC)

http://www.psc.gov

To provide a full range of support services to HHS and other Federal agencies, allowing them to focus on their core mission. PSC, a component of ASAM, is the Department's Shared Services Center, providing services on a fee-for-service basis to customers across the Federal Government in administrative operations, financial management, enterprise support, strategic acquisitions, and occupational health service.

APPENDIX G

Acronyms

Acronyms

ACF	Administration for Children and Families
AD	Alzheimer's disease
ADD	Administration on Developmental Disabilities
AERS	Adverse Event Reporting System
AFI	Assets for Independence
AFL	Adolescent Family Life Program
AHIC	American Health Information Community
AHRQ	Agency for Healthcare Research and Quality
AI/AN	American Indian and Alaska Native
ANA	Administration for Native Americans
AoA	Administration on Aging
ASAM	Assistant Secretary for Administration and Management
ASH	Assistant Secretary for Health
ASL	Assistant Secretary for Legislation
ASPA	Assistant Secretary for Public Affairs
ASPE	Office of the Assistant Secretary for Planning and Evaluation
ASPR	Office of the Assistant Secretary for Preparedness and Response
ASRT	Office of the Assistant Secretary for Resources and Technology
ATR	Access to Recovery
ATSDR	Agency for Toxic Substances and Disease Registry
ATTC	Addiction Technology Transfer Center
BARDA	Biomedical Advanced Research and Development Authority
BRIC	Building Research Infrastructure and Capacity Program
CARE	Comprehensive AIDS Resources Emergency
CCCLI	Comprehensive Cancer Control Leadership Institutes
CCDE	Cash and Counseling Demonstration Evaluation
CCHIT	Certification Commission for Health Care Information Technology
CDC	Centers for Disease Control and Prevention
CFBCI	Center for Faith-Based and Community Initiatives
CHGME	Children's Hospitals Graduate Medical Education
CISA	Clinical Immunization Safety Assessment
CMS	Centers for Medicare & Medicaid Services
CNCS	Corporation for National and Community Service
COSIG	Co-Occurring State Incentive Grant
CPI	Critical Path Initiative
CPIC	Capital Planning and Investment Control
CRADA	Cooperative Research and Development Agreement
CSE	Child Support Enforcement
CY	Calendar Year
DAB	Departmental Appeals Board
DMAT	Disaster Medical Assistance Team
DRA	Deficit Reduction Act of 2005 (Public Law 109-171)
DTaP	Diphtheria-Tetanus-Pertussis
EA	Enterprise Architecture
EEO	Equal Employment Opportunity
EPA	U.S. Environmental Protection Agency
ESAR-VHP	Emergency System for Advanced Registration of Volunteer Health Professionals
ESF	Emergency Support Function
FACES	Family and Child Experiences Survey

FDA	Food and Drug Administration
FFS	Fee-For-Service
FHA	Federal Health Architecture
FPL	Federal Poverty Level
FTE	Full-time equivalent employee
FY	Fiscal Year
FYSB	Family and Youth Services Bureau
GDP	Gross Domestic Product
GI	Gastrointestinal
GME	Graduate Medical Education
GPEI	Global Polio Eradication Initiative
GPRA	Government Performance and Results Act of 1993 (Public Law 103-62)
HACCP	Hazard Analysis Critical Control Point
HCV	Hepatitis C virus
HHS	U.S. Department of Health and Human Services
Hib	Haemophilus influenzae type b
HIPAA	Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191)
HITSP	Health Information Technology Standards Panel
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
H.R.	House of Representatives bill (with number)
HRSA	Health Resources and Services Administration
HSA	Health Savings Account
HUD	U.S. Department of Housing and Urban Development
IDA	Individual Development Account
IGA	Office of Intergovernmental Affairs
IHS	Indian Health Service
IPV	Intimate Partner Violence
IT	Information technology
ITN	Insecticide-treated bed net
LEP	Limited English Proficiency
LIHEAP	Low Income Home Energy Assistance Program
M-RISP	Minority Research Infrastructure Support Program
MCP	Mentoring Children of Prisoners
MDG	Millennium Development Goal
MIIR	Management Information Integrity Repository
MMA	Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173)
MMR	Measles-Mumps-Rubella
MRC	Medical Reserve Corps
MRS	Magnetic Resonance Spectroscopic Imaging
MSA	Medical Savings Account
NCHS	National Center for Health Statistics
NCTR	National Center for Toxicological Research
NCTSI	National Child Traumatic Stress Initiative
NDMS	National Disaster Medical System
NHSC	National Health Service Corps
NICHD	National Institute of Child Health and Human Development
NIH	National Institutes of Health
NRC	National Resource Center
NRP	National Response Plan
OCR	Office for Civil Rights
OD	Office on Disability

OGC	Office of the General Counsel
OGHA	Office of Global Health Affairs
OIG	Office of Inspector General
OMB	Office of Management and Budget
OMH	Office of Minority Health
OMHA	Office of Medicare Hearings and Appeals
ONC	Office of the National Coordinator for Health Information Technology
OPHS	Office of Public Health and Science
ORR	Office of Refugee Resettlement
OS	Office of the Secretary
OSG	Office of the Surgeon General
PAC	Post-acute care
PACE	Program of All-Inclusive Care for the Elderly
PAHPA	Pandemic and All-Hazards Preparedness Act of 2006 (Public Law 109-417)
PAR	Performance and Accountability Report
PART	Program Assessment Rating Tool
PATH	Projects for Assistance in Transition from Homelessness
PCV7	Pneumococcal conjugate vaccine
PDM	Personal dust monitor
PDUFA	Prescription Drug and User Fee Act
PEPFAR	President's Emergency Plan for AIDS Relief
PHIN	Public Health Information Network
PMAP	Performance Management Appraisal Program
PMI	President's Malaria Initiative
PSC	Program Support Center
PSSF	Promoting Safe and Stable Families
PSUNC	Parents Speak Up National Campaign
QI	Quality Indicator
RD&E	Research, Demonstration, and Evaluation
SAMHSA	Substance Abuse and Mental Health Services Administration
SARS	Severe Acute Respiratory Syndrome
SBIRT	Screening, Brief Intervention, and Referral and Treatment Program
SCHIP	State Children's Health Insurance Program
SES	Senior Executive Service
SIDS	Sudden Infant Death Syndrome
SIG	State Incentive Grant
SNS	Strategic National Stockpile
SPARC	Sickness Prevention Achieved through Regional Collaboration
SPF	Strategic Prevention Framework
TANF	Temporary Assistance for Needy Families
USAID	United States Agency for International Development
USC	United States Code
USICH	United States Interagency Council on Homelessness
USPHS	United States Public Health Service
USPSTF	United States Preventive Services Task Force
VA	U.S. Department of Veterans Affairs
VAERS	Vaccine Adverse Event Reporting System
VFC	Vaccines for Children Program
VICP	Vaccine Injury Compensation Program
WHO	World Health Organization

APPENDIX H

Endnotes

Endnotes

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