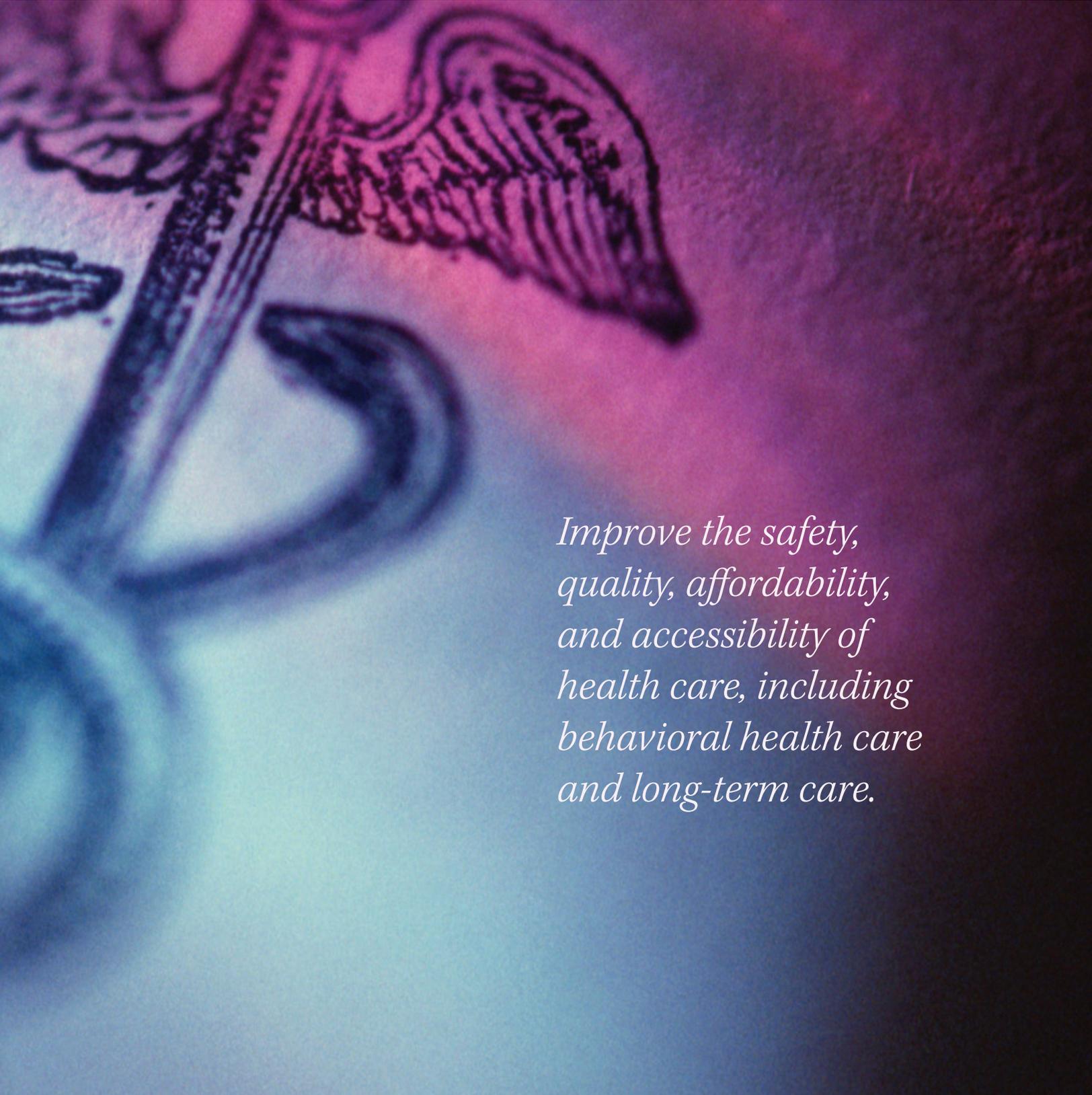Chapter 2
Strategic Goal 1:
Health Care

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

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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.

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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.

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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.

In the Spotlight

Reducing Health Disparities

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-His-

panic 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.

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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.

In the Spotlight

Advancing the Development and Use of Health Information Technology

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.