United States
Department of Health & Human Services

HHS ANNUAL PLAN

FY 2007

HHS MISSION

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

HHS STRATEGIC GOALS

In FY 2004 HHS updated its Strategic Plan identifying eight strategic outcome goals for accomplishing the Department's mission for FY 2004 - 2009.

The Strategic Plan contains the following Strategic Goals:

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

Strategic Goal 2 - *Enhance the ability of the Nation's health care system to effectively respond to terrorism and other public health challenges.*

Strategic Goal 3 - *Increase the percentage of the Nation's children and adults who have access to health care services, and expand consumer choices.*

Strategic Goal 4 - *Enhance the capacity and productivity of the Nation's health science research enterprise.*

Strategic Goal 5 - *Improve the quality of health care services.*

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

Strategic Goal 7 - *Improve the stability and healthy development of our Nation's children and youth.*

Strategic Goal 8 - *Achieve excellence in management practices.*

HIGHLIGHTS OF HHS ACCOMPLISHMENTS

36	Percent of patients with diabetes who received care through the Indian Health Service demonstrated ideal blood sugar control during FY 2005, a two percent increase from FY 2004. (IHS)
69	Percent of Head Start teachers hold an associate, baccalaureate or advanced qualifying degree, exceeding the FY 2005 target of 65 percent. (ACF)
73	Percent of clinicians at Huron Hospital utilize Computerized Physician Order Entry, and residents are placing 93% of their orders in the Electronic Medical Record. (AHRQ)
91	Percent of original generic drug applications were reviewed and acted on by the Center for Drug Evaluation and Research within six months of submission. (FDA)
96	Percent of participants in Substance Abuse Prevention Programs of Regional and National Significance rated substance abuse as wrong or very wrong in FY 2004. (SAMHSA)
100	Microarray datasets derived from National Institute of Environment Health Sciences/ National Center for Toxicogenomics Research, as well as pharmaceutical companies, were deposited in Chemical Effects in Biological Services. (NIH)
70,926	Field examinations of imported food wer conducted by the Center for Food Safety and Applied Nutrition and Office of Regulatory Affairs in FY 2004 (a 6-fold increase from 12,000 field import examinations conducted in FY 2001). (FDA)
293,500	Severely disabled elders received home-delivered meals in 2004, allowing more elders to remain in their homes in the community. (AoA)
534,000	TANF recipients were placed by states in new jobs in 2004. (ACF)
700,000	OraQuick rapid HIV test kits have been purchased and distributed by CDC since 2003. The test kits have been used by 137 health departments and Community Based Organizations in settings lacking immediate access to clinical laboratory services. (CDC)
5,696,526	People served by the public mental health system in FY 2004. (SAMHSA)
6,900,000	Children enrolled in the State Children's Health Insurance Program in FY 2004. (CMS)
13,120,000	Persons were provided access to primary and preventive health care in FY 2004 through the Health Centers program. (HRSA)
30,000,000	Americans would be protected from the effects of anthrax exposure due to antibiotic purchases for the Strategic National Stockpile in 2004. (CDC)
41,900,000	Poor and disabled individuals provided medical assistance by Medicaid in FY 2005. (CMS)
42,400,000	Individuals covered by Medicare in FY 2005.(CMS)
21,900,000,000	Billion dollars in child support payments were collected and distributed, representing a 3.2 percent increase over the previous fiscal year. (ACF)

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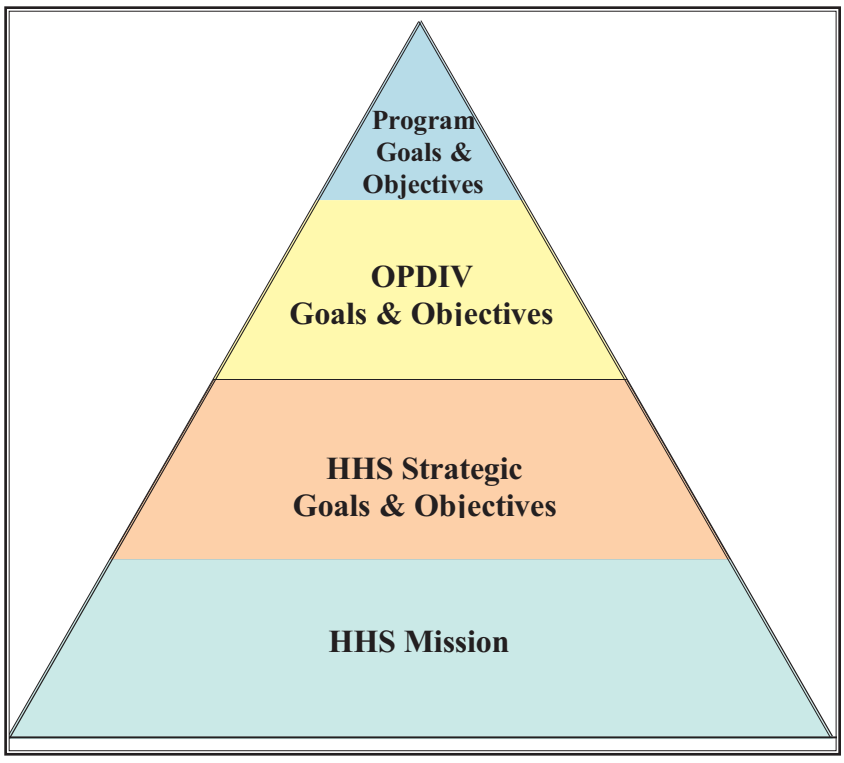
OVERVIEW

The U.S. Department of Health and Human Services' (HHS) FY 2007 Annual Plan highlights 20 HHS programs with 24 corresponding performance goals that reflect some of the work HHS is achieving in support of the HHS Strategic Plan. The Government Performance and Results Act (GPRA) provides the statutory framework for performance planning and requires the development of a five-year Strategic Plan, Annual Plan, Annual Performance Report, and program performance goals. The HHS Strategic Plan, most recently updated in FY 2004, includes eight strategic goals that link to the accomplishment of the Department's mission in FY 2004 - FY 2009. This FY 2007 HHS Annual Plan provides readers with a sense of the far-reaching and positive effects of HHS programs.

To gauge program effectiveness, HHS uses performance measures as a basis for comparing actual program results with established program performance goals. The HHS Operating Division's (OPDIV) FY 2007 Annual Plans contain over 700 hundred performance goals that HHS OPDIVs track and report annually in their Congressional Justifications. Given the large number and complexity of programs and measures, HHS highlights some key performance goals in this FY 2007 HHS Annual Plan to illustrate the Department's priorities and goals for FY 2007. The highlighted programs in this report were selected so that each OPDIV in the Department is represented and that there is at least one major program initiative that aligns with each strategic goal. For more detailed information on all of HHS programs and performance goals, please see http://www.hhs.gov/budget/.

The overview section of the FY 2007 HHS Annual Plan includes Highlights of HHS Accomplishments, the Budget by Strategic Goal table, an analysis of Program Assessment Rating Tool (PART) reviews, and an overview of the President's Management Agenda (PMA). The narrative discussion for each highlighted program and corresponding measures in this report are presented based on the strategic goal each supports. Numerous HHS programs are implemented in coordination with State, local, Tribal, and non-governmental partners. Therefore, in many cases the strategic goals, performance goals, and program results reflect the combined commitment and effort of HHS and its partners.



Planning and Performance at HHS

HHS manages hundreds of programs that aim to improve health status, increase access to health services, and create opportunities for disadvantaged individuals to work and lead productive lives. HHS programs reach all Americans by providing health and social services, protecting public health, and funding biomedical research. HHS is one of the largest Federal agencies, the Nation's largest health insurer, and the largest grant-making agency in the Federal government. HHS uses strategic planning, annual performance planning, and the annual budget process to identify policy and program priorities. The HHS Strategic Plan along with the Secretary's 500 Day Plan and the PMA provide the overarching long-term goals and framework for the Department's OPDIVs and Staff Divisions (STAFFDIVs) to use on an annual basis to create an annual performance plan.

The HHS annual Performance Budgets present the resource needs of HHS programs and identify the results that Americans can expect from their investment in these programs. The Performance Budgets state planned goals and also report on past achievements of all HHS programs. Linkages between HHS Strategic Plan, HHS Annual Plan, and Performance Budgets are illustrated in a table that displays the HHS Budget by Strategic Goal on page four in the FY 2007 HHS Annual Plan. At the close of each fiscal year, HHS produces a Performance and Accountability Report (PAR), which incorporates performance results with audited financial statements for the year. The PAR highlights illustrative programs to report on HHS performance. Together the Annual Plan and the PAR constitute an annual planning and reporting process for HHS programs.

500-Day Plan

In May 2005, HHS Secretary Michael O. Leavitt introduced his 500-Day Plan, which outlines his priorities for the Department. The 500-Day Plan supports the Strategic Plan in guiding the Department in achieving its broad policy and program objectives. The six initiative areas in the 500-Day Plan are:

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

Secretary Mike Leavitt uses the 500-Day Plan as a management tool guiding his and the Department's energies in fulfilling the President's vision of a healthier and more hopeful America. Secretary Leavitt stated, "I enjoy solving problems and am guided by selected long-term goals. I then rely on a 500-day plan to create a timetable of short-term actions that chart a course for future progress." The initiatives in the 500 Day Plan focus on actions during a 500-day period that will achieve significant progress and from which the American people will benefit over a 5,000-day horizon. For more information, visit www.hhs.gov/500DayPlan.

Changes to the Performance Budgets

The FY 2007 HHS Performance Budgets include several changes to improve the integration of budget and performance information. In the Performance Budget Overview, each OPDIV includes a table that links their OPDIV strategic goals to the HHS-Strategic Goals. The Performance Detail now directly follows the Narrative by Activity to better inform the budget justification. The Performance Detail also contains a reformatted performance measure table that shows both the long term and annual goal with targets and results. The new format also incorporates information on the data source and data validation directly into the table. Each of these improvements advances the objective of integrating performance and budget information in the HHS budget.

Evaluation and Assessment

HHS annually conducts evaluations to review program effectiveness, develop performance measures, assess environmental impacts on health and human services, and improve program management. HHS program managers use the results of these program evaluations in the annual planning and budget process. Annually, the Department also sends reports to Congress describing these evaluation activities: the Research, Demonstration, and Evaluation reports and the Public Health Service Evaluation Set-aside report. In addition, the Office of the Inspector General annually produces a Work Plan which identifies program evaluations that will be conducted by that organization. HHS' evaluation activities provide important information about HHS programs which supports and supplements the Department's ability to evaluate and assess program performance.

BUDGET BY STRATEGIC GOALS

The work of each HHS OPDIV and STAFFDIV contributes to achieving the Department's eight strategic goals. The charts below show a breakdown of the total HHS budget and discretionary budget by HHS strategic goal. The total FY 2007 HHS budget is approximately $696 billion (in program level) of which approximately 90 percent is mandatory spending and 10 percent is discretionary. Medicare and Medicaid account for almost 94 percent of the total mandatory level and both programs support HHS Strategic Goal 3. As a result, the total budget by strategic goal table is heavily influenced by the size of the Medicare and Medicaid programs. This display should not be used to determine how much each program activity contributes to any one strategic goal since programs may in reality contribute to a number of strategic goals.

HHS Strategic Goals:

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

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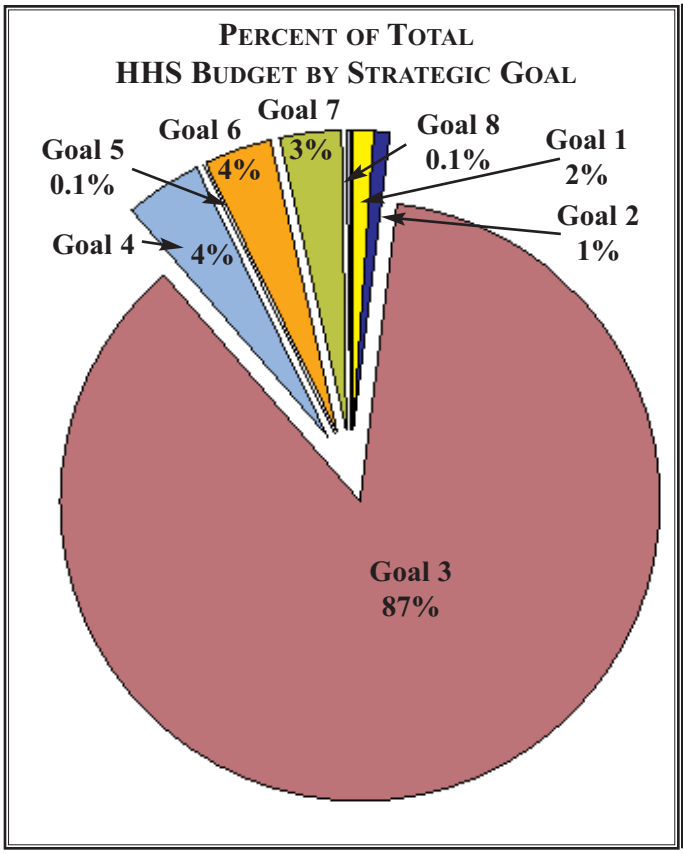
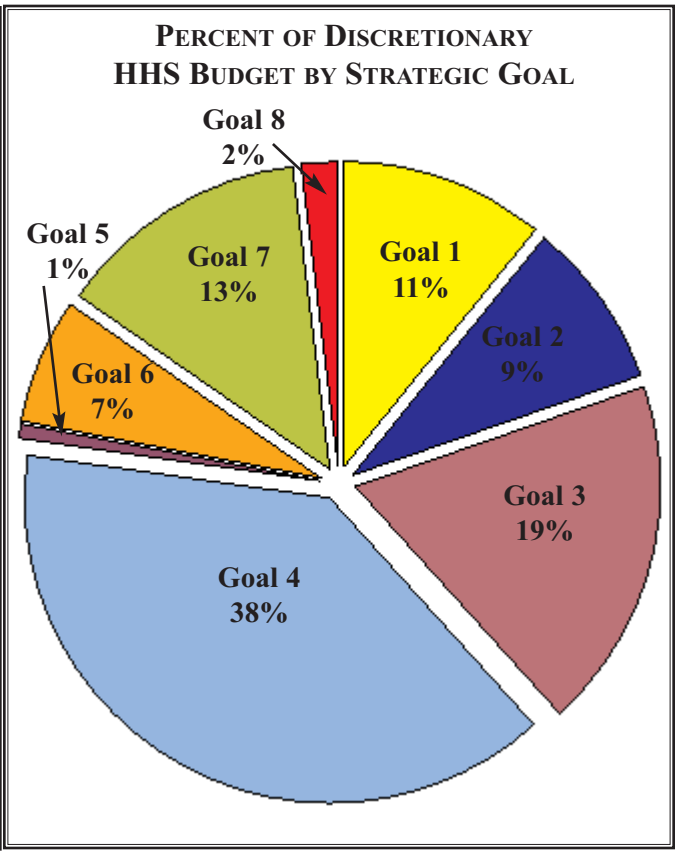




PROGRAM ASSESSMENT RATING TOOL (PART)

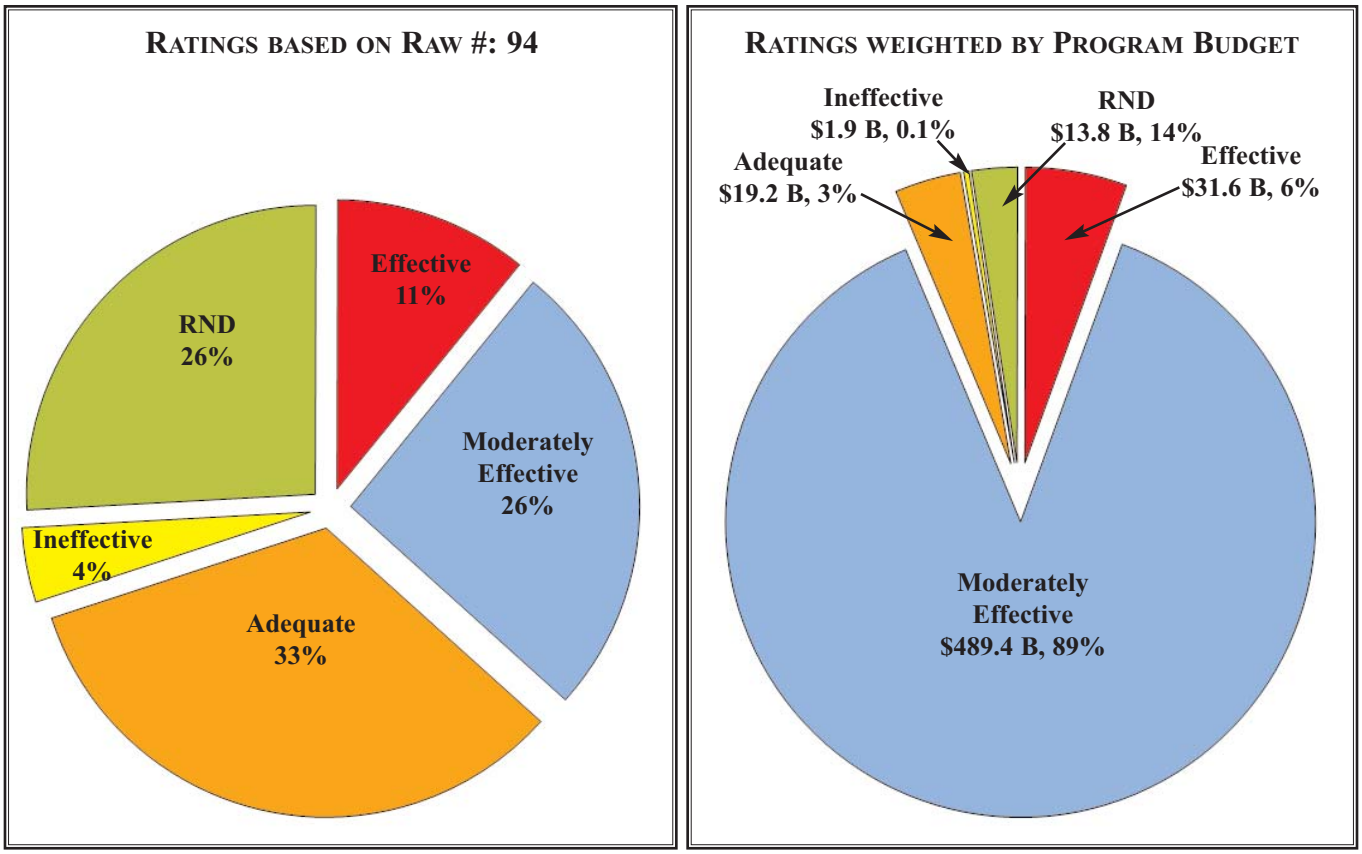
Program Assessment Rating Tool (PART)

In 2002, OMB introduced the Program Assessment Rating Tool (PART) to examine the effectiveness of all Federal programs. Its overall purpose is to assess program performance and results. The PART contains four sections: program purpose and design, strategic planning, program management, and program results. Programs receive numerical scores for each section with the program results section accounting for 50 percent of the overall score. Programs also receive narrative ratings of Effective, Moderately Effective, Adequate, Ineffective, and Results Not Demonstrated.

HHS uses PART to inform management and budget decisions throughout the year and to improve program performance and efficiency. PART results are included each year in the Department's summer budget process. Additionally, HHS implemented an internal process to ensure that programs use the PART information to improve program performance, specifically programs that received a Results Not Demonstrated (RND) rating.

In 2005, OMB reviewed 31 HHS programs using PART. Since 2002, a total of nearly 100 programs have been assessed by PART. Seventy percent of HHS programs received a rating of Adequate or higher and on a program dollar weighted basis 98 percent of programs are rated Adequate or higher. This percentage includes mandatory programs, which account for 88 percent of the total PART program's budget. OPDIVs discuss actions they are taking in response to PART assessments in their Performance Budget. For more detailed information on PART results for HHS programs please see http://www.ExpectMore.gov.

HHS PART Ratings



PRESIDENT'S MANAGEMENT AGENDA

The President's Management Agenda (PMA) along with the HHS Strategic Plan and the Secretary's 500 Day Plan provide a framework for improving the management and performance of the Federal government. Through implementation of the PMA, HHS has taken significant steps to institutionalize its focus on results and acheive improved program performance that is important to the HHS mission and the American taxpayer.

The following provides an update on PMA initiatives at HHS as of January 4, 2006.

PMA Initiatives:	Status	Progress
Strategic Management of Human Capital	**Green** 	**Green** 
Competitive Sourcing	**Green** 	**Green** 
Improved Financial Performance	**Red** 	**Green** 
Expanded Electronic Government	**Yellow** 	**Green** 
Budget and Performance Integration	**Yellow** 	**Green** 

PMA Program Initiatives:	Status	Progress
Broadening Health Insurance Coverage through State Initiatives	**Yellow** 	**Green** 
Eliminating Improper Payments	**Red** 	**Green** 
Real Property Asset Management	**Yellow** 	**Green** 
Faith Based and Community Initiative	**Yellow** 	**Green** 

STRATEGIC GOAL 1

Reduce the Major Threats to the Health and Well-Being of Americans

Highlighted Programs:

1a. National Immunization Program (CDC)

1b. HIV/AIDS Prevention in the U.S. (CDC)

1c. Substance Abuse Prevention and Treatment Block Grant (SAMHSA)

Each year, HHS has the opportunity to renew its commitment to reduce health threats and promote healthy behaviors. This commitment remains a critical priority for FY 2007. This goal supports the Department's vision to improve the health and well being of people in this country and throughout the world. HHS recognizes that this vision can only be accomplished through coordination across the Department, and through partnerships with States, communities, and health professionals.

Twelve HHS programs in four OPDIVs contribute to achieving this strategic goal. This report highlights three programs including the Centers for Disease Control and Prevention's (CDC) National Immunization Program, CDC's HIV/AIDS Prevention, and the Substance Abuse and Mental Health Administration's (SAMHSA) Substance Abuse Prevention and Treatment Block Grant program.

HHS has made great strides in increasing the number of children who are immunized. Childhood immunization rates are at record high levels, but a substantial number of children in the United States are not adequately protected from vaccine-preventable diseases. The FY 2007 budget funding for immunizations will be used to help ensure that no child, adolescent, or adult will needlessly suffer from a vaccine-preventable disease. Prevention remains at the center of the HHS approach to fighting HIV/AIDS, sexually transmitted diseases, and tuberculosis. HHS is making considerable progress toward slowing the transmission of HIV from pregnant women to their children and preventing the spread of tuberculosis.

Through the Substance Abuse Prevention and Treatment Block Grant program, states and territories provide alcohol and drug treatment and prevention services. HHS continues to work with the Office of National Drug Control Policy to implement an effective drug strategy that will increase the number of individuals provided with effective substance abuse treatment.

PROGRAM 1A: NATIONAL IMMUNIZATION PROGRAM
Centers for Disease Control and Prevention (CDC)

Performance Measure: *Achieve or sustain immunization coverage of at least 90% in children 19- to 35-months of age for: 4 doses DTaP vaccine1, 3 doses Hib vaccine, 1 dose MMR vaccine2, 3 doses hepatitis B vaccine, 3 doses polio vaccine, 1 dose varicella vaccine, 4 doses pneumococcal conjugate vaccine (PCV7)3*

The success of CDC's immunization efforts continues in large part due to ambitious goals, one of which includes an FY 2007 target to ensure that 90 percent of all children age 19-35 months of age are appropriately vaccinated. The incidence of vaccine-preventable diseases declines significantly as CDC's childhood immunization coverage activities increase.

The target of 90 percent coverage was met in 2004 for most individual vaccines, except varicella and diphtheria-tetanus-acellular pertussis (DTaP). In 2004, the coverage rate for four doses of DTaP containing vaccine did not yet achieve the 90 percent goal. However, the coverage rate for the fourth dose has steadily increased since the change to a four dose schedule, as recommended by the Advisory Committee on Immunization Practices (ACIP) in 1991. This goal continues to be difficult to achieve because it requires that the fourth dose be given to the child between 15 and 18 months of age. The administration of DTaP tends to coincide with regular well-baby visits through the third dose; however, the fourth dose does not, requiring a visit specifically for this purpose. Coverage rates are 96 percent for the first three DTaP doses. In 2002 and 2003, CDC modified reporting on DTaP from four doses to three doses because vaccine shortages limited the availability of the fourth dose. This change was made because the ACIP recommends that if this vaccine is in short supply, or not available, the fourth dose of DTaP may be dropped. The performance reporting change was temporary and reporting for the fourth dose has now been implemented.

Performance Measure: Achieve or sustain immunization coverage of at least 90% in children 19- to 35-months of age for: 4 doses DTaP vaccine[1], 3 doses Hib vaccine, 1 dose MMR vaccine[2], 3 doses hepatitis B vaccine, 3 doses polio vaccine, 1 dose varicella vaccine, 4 doses pneumococcal conjugate vaccine (PCV7)[3]

Year	Target	Result
2007	90% coverage	8/2008
2006	90% coverage	8/2007
2005	90% coverage	8/2006
2004	90% coverage	DTaP 86%; Hib 94%; MMR 93%; Hepatitis B 92%; Polio 92%; Varicella 88%
2003	90% coverage	DTaP 96%; Hib 94%; MMR 93%; Hepatitis B 92%; Polio 92%; Varicella 85%
2002	90% coverage	DTaP 95%; Hib 93%; MMR 91%; Hepatitis B 90%; Polio 90%; Varicella 81% (exceeded with the exception of Varicella)

Data Source: Data are collected through the National Immunization Survey (NIS) and reflect calendar years.

Data Validation: The NIS uses random-digit-dialing to find households with children aged 19 to 35 months. Parents or guardians verbally provide the vaccines–with dates–that appear on the child's "shot card" kept in the home; and demographic and socioeconomic information is asked. Permission is asked to contact the child's vaccination providers. Providers are contacted by mail to verify each child's vaccinations. The NIS uses a nationally representative sample, and provides estimates of coverage that are weighted to represent the entire population, nationally, and by region, state, and selected large metro areas. The large sample size allows for stratification of the data so that vaccination rates among different groups, for instance, by income level, race, education level of mothers, and other factors can be examined.

Performance Budget Reference: CDC FY 2007 CJ.

1 Due to a shortage in vaccine and temporary change in recommendations, 3 doses were reported from 2002 – 2003.
2 Includes any measles-containing vaccine.
3 Performance targets for any newly recommended vaccines, such as pneumococcal conjugate vaccine and influenza vaccine, are reported in GPRA five years after ACIP recommendation. Measures for pneumococcal conjugate vaccine (PCV7) will begin in 2006 and influenza in 2009.

Varicella is the most recently introduced vaccine that has a measurable target. Varicella vaccination rates are rising with coverage at only 43 percent in 1998, reaching 88 percent in 2004. CDC is close to meeting the 90 percent varicella vaccine coverage goal which is especially impressive this soon after the introduction of this particular vaccine, since a child that has already been exposed to chickenpox does not receive the varicella vaccine.

The prevention of pneumococcal infections with pneumococcal conjugate vaccine (PCV) is becoming more important due to problems with treatment as a result of increasing antibiotic resistance. ACIP added PCV to the 2001 Recommended Childhood Immunization Schedule. As this vaccine was recently recommended, accountability for performance targets will begin in 2006. The vaccination coverage level for PCV in 2004 is 73.2 percent.

Vaccines are one of the most successful and cost effective public health tools for preventing disease and death. An economic evaluation of the impact of seven vaccines (DTaP, Td, Hib, polio, MMR, hepatitis B, and varicella) routinely given as part of the childhood immunization schedule found that vaccines are tremendously cost effective. One dollar spent on these seven vaccines results in $16.50 saved. Routine childhood vaccination with these seven vaccines, which prevents over 14 million cases of disease and over 33,500 deaths, resulted in annual cost saving of $10 billion in direct medical cost and over $40 billion in indirect societal costs. This study in the Archive of Pediatrics and Adolescent Medicine is the first time the seven vaccine series has been examined together with a common methodology.[1]

COST-EFFECTIVENESS OF CHILDHOOD VACCINES [2]

For every $1 spent on an individual vaccine:
- DTaP saves $27
- MMR saves $26
- Perinatal Hepatitis B saves $14.70
- Varicella saves $5.40
- Inactivated Polio (IPV) saves $5.45

For every $1 spent:
- Childhood series 7 vaccines saves $16.50*

* (DTaP, Td, Hib, IPV, MMR, Hep B and Varicella)

[1] Zhou, et al., Archives Pediatric Adolescent Medicine, 159(Dec 2005):1136-1144

[2] DTaP: Ekwueme et al, Archives Pediatric Adolescent Medicine, 154(Aug 2000): 797-803
MMR: Zhou, et al., J Infectious Disease, 189(2004): S131-145
Hib: Zhou, et al., Pediatrics, 110:4(Oct 2002): 653-661
HepB: Zhou, et al., CDC unpublished data
Varicella: Lieu, et al., JAMA, 271(1994): 375-81
IPV: Zhou, et al., CDC unpublished data.

PROGRAM 1B: HIV/AIDS PREVENTION IN THE U.S.
Centers for Disease Control and Prevention (CDC)

Performance Measures

Reduce the number of HIV infection cases diagnosed each year among people under 25 years of age, from 2,100 in 2000.

Decrease the number of perinatally acquired AIDS cases from the 1998 base of 235 cases.

CDC's overarching goal in HIV is to reduce the number of new HIV infections in the U.S. as measured by the number of HIV infections diagnosed each year among people less than 25 years of age. CDC's goal is consistent with HHS's strategic goal to reduce the major threats to the health and well-being of Americans.

Performance Measure: Reduce the number of HIV infection cases diagnosed each year among people under 25 years of age, from 2,100 in 2000.

Year	Target[1]	Result
2007	<4,000 reported cases in 30 areas	11/2008
2006	**2,420 reported cases in 30 areas	11/2007
2005	1,800 reported cases in 25 states	11/2006
2004	1,900 reported cases in 25 states	2,606* in 25 states*; 3,465 in 30 areas** (Unmet)
2003	N/A	2,286*** in 25 states*; 3,134 in 30 areas**
2002	N/A	2,154*** in 25 states*; 3,028** in 30 areas**

Data Source: HIV/AIDS Reporting System (HARS)

Data Validation: HIV data collection systems vary between areas (e.g., name-based code, coded identifier, name-to-code data collection systems). CDC recommends that all states and territories adopt confidential name-based HIV surveillance systems. As of November 2005, 43 states and territories use confidential name-based HIV surveillance while 13 other state and local health departments used code-based or name-to-code methods.

*The 25 states with mature, stable HIV surveillance systems at baseline are: Alabama, Arizona, Arkansas, Colorado, Idaho, Indiana, Louisiana, Michigan, Minnesota, Mississippi, Missouri, Nevada, New Jersey, North Carolina, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Utah, Virginia, West Virginia, Wisconsin, Wyoming.

**The 30 area comparison group includes the 25 states listed above plus Florida, Iowa, Nebraska, New Mexico, and the U.S. Virgin Islands.

***The period of time between a diagnosis of HIV or AIDS and the arrival of a case report at CDC is called the "reporting delay". In order to provide the best estimates of recent trends, HIV and AIDS surveillance data are analyzed by date of diagnosis and are statistically adjusted for reporting delays and incomplete information on some cases. CDC requires a minimum of 12 months after the end of a calendar year to provide accurate estimates of trends for that year. All data have been modified to update annual "actual performance" numbers based on the most recent HIV/AIDS surveillance data. Therefore, estimates vary slightly from year to year.

Performance Budget Reference: CDC FY 2007 CJ.

[1] This measure was first reported in FY 2004 and therefore, targets begin in FY 2004. However, actual performance is shown for previous years because the data was available, even though it was not reported in the form of a measure.

The number of HIV infection cases among persons under 25 years of age diagnosed each year is currently the best data available to monitor new HIV infections. HIV infections occurring in this group are likely to have been acquired recently and thus are a relatively good proxy measure of HIV incidence. In 2004, there were 2,606 cases reported in 25 areas with confidential name-based reporting. The increase in number of reported cases of HIV/AIDS may reflect both increases in testing for HIV and true increases in HIV among those under 25. For example, recent initiatives to promote HIV testing may have resulted in an increase in the identification of HIV infections among the previously undiagnosed, thus increasing the number of cases that are reported to the health departments. True increases in HIV may have occurred and may be related to recent increases in syphilis and other STDs, which increase risk of HIV transmission and have been reported among men who have sex with men in the U.S. Further, with better survival due to treatment, the overall number of persons living with HIV is increasing, which in turn increases the probability of infection for young persons engaging in high-risk behaviors. Recent initiatives to greatly expand HIV testing are expected to have a substantial impact on the proportion of infected persons who are diagnosed. Therefore, in

the short term, the number of cases diagnosed and reported to CDC is expected to rise. The FY 2007 target has been adjusted accordingly. In the long-term, helping people learn of their infection and providing them prevention services is expected to decrease the number of new infections.

Initially, targets were set when only 25 states had stable, confidential name-based HIV reporting. In 2004, additional data were available from five states and territories and the FY 2006 and FY 2007 targets were adjusted to reflect the total 30 areas. Both are reported for purposes of comparison.

Performance Measure: Decrease the number of perinatally acquired AIDS cases from the 1998 base of 235 cases.

Year	Target	Result
2007	<100 cases	11/2008
2006	<100 cases	11/2007
2005	<100 cases	11/2006
2004	<100 cases	48*
2003	<139 cases	69* (Exceeded)
2002	141 cases	109* (Exceeded)

Data Source: Adult and Pediatric Confidential HIV/AIDS Case Reports (OMB Control No. 0920-0573)

Data Validation: HIV/AIDS data are collected by state and local health departments and forwarded to CDC, without identifying information, and are published in annual surveillance reports. AIDS data presented here are from all 50 States, DC, Guam, PR, the Pacific Islands and the U.S. VI.

Performance Budget Reference: CDC FY 2007 CJ

* All data have been modified to update annual "actual performance" numbers based on the most recent HIV and AIDS Surveillance data. Therefore, some values have changed for prior years.

A dramatic reduction in perinatal (mother-to-child) HIV transmission cases has been noted in the U.S., a result of the widespread implementation of the Public Health Service (PHS) recommendations made in 1994 and 1995. Recommendations included routinely counseling and voluntarily testing pregnant women for HIV, and offering zidovudine (AZT) to infected women during pregnancy and delivery, and their infants, post-partum. Further decreasing perinatal HIV transmission is one of four strategies included in CDC's Advancing HIV Prevention (AHP) Initiative. To support this key strategy, CDC issued recommendations that clinicians routinely screen all pregnant women for HIV infection and that jurisdictions with statutory barriers to such routine prenatal screening consider revising them. With these efforts and increased treatment of those infected, the number of perinatally acquired AIDS cases is likely to remain low. However, declines may be affected by treatment failures and missed opportunities to prevent transmission. Data for 2004 continues to show low levels of perinatally acquired AIDS cases. The target for FY 2007 is less than 100 cases.

PROGRAM 1C: SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT

Substance Abuse and Mental Health Services Administration (SAMHSA)

Performance Measure: *Increase the number of clients served.*

The goal of SAMHSA's Substance Abuse Prevention and Treatment Block Grant is to improve the health of the Nation by bringing effective alcohol and drug treatment and prevention services to States and Territories through block grants. The block grant supports and expands substance abuse prevention and treatment, while providing maximum flexibility to the states. States and territories may expend block grant funds only for the purpose of planning, carrying out, and evaluating activities related to these services. The block grant is the cornerstone of states' substance abuse programs and is central to HHS's strategic goal of reducing substance abuse. States are heavily dependent upon block grant funding for urgently needed substance abuse services.

The FY 2007 target for treatment admissions is 2,003,324. The FY 2003 target was missed slightly; because, the data from SAMHSA's Treatment Episode Data Set (TEDS) is a proxy for this measure, representing treatment admissions rather than the total number served. Proxy data are used because many states currently are unable to employ a unique client identifier, which is necessary in order to track unduplicated numbers of clients served. The FY 2003 is the most recent year for which data are currently available, because of the time required for states to report data on the number of admissions in any given year.

Performance Measure: Increase the number of clients served.

Year	Target	Result
2007	2,003,324	10/2009
2006	1,983,490	10/2008
2005	1,963,851	10/2007
2004	1,925,345	10/2006
2003	1,884,654	1,840,275
2002	1,751,537	1,882,584

Data Source: Substance Abuse and Mental Health Services Administration, Office of Applied Studies, Treatment Episode Data Set (TEDS)

Data Validation: Treatment Episode Data Set data represent admissions to treatment, not the total number of individual clients served, and are used as a proxy for this measure. Detailed instructions for data submission, review, and cleaning are available at http://wwwdasis.samhsa.gov/dasis2/teds.htm

Performance Budget Reference: SAMHSAFY 2007 CJ, Pg. PD33.

This measure is one of SAMHSA's National Outcome Measures, which, when fully implemented by the end of FY 2007, will provide more direct and accurate data on number of clients served by reporting an unduplicated count of clients. The unduplicated reporting will be phased in among the States. States are working toward providing unduplicated counts of the number of clients served. As States begin to report unduplicated counts, TEDS might show that that the number of admissions has gone down, since readmissions of the same individual in the reporting period would be counted as a single client served. Targets may be adjusted to reflect this change. Performance is also affected by the status of the national economy, including changes in employment and insurance coverage for substance abuse and mental health services; the amount of resources that states and communities are able to allocate to prevention and treatment of substance abuse; and the variation in the supply of (and demand for) illegal drugs such as heroin and cocaine, as well as new addictive substances.

An evaluability assessment of the Substance Abuse Prevention and Treatment Block Grant was completed in December 2004. A comprehensive evaluation is under development, with results expected in late 2006.

STRATEGIC GOAL 2

Enhance the Ability of the Nation's Health Care System to Effectively Respond to Terrorism and Other Public Health Challenges

Highlighted Programs:

2a. Field Foods Program (FDA)

2b. Bioterrorism Hospital Preparedness Program (HRSA)

2c. Terrorism Preparedness and Emergency Response Program (CDC)

HHS has a number of initiatives and programs directed at protecting Americans from bioterrorist attacks and other public health challenges. The events of September 11, 2001 and subsequent anthrax attacks have reinforced the HHS role in protecting Americans from attacks on our health and food supply by enhancing preparedness and response capabilities.

Approximately seven HHS programs in six OPDIVs contribute to achieving this strategic goal. Three programs are highlighted in this strategic goal including the Food and Drug Administration's (FDA) Field Food Program, Health Resources and Services Administration's (HRSA) Hospital Preparedness Program, and CDC's Terrorism Preparedness and Emergency Response Program.

In addition to responsive regulatory review of new biodefense medical countermeasures, FDA inspects high risk domestic food manufacturers and enhances food import inspections to protect our Nation's food supply and prevent food borne illness. HRSA assists hospitals and other medical facilities to prepare for health consequences of bioterrorism and other mass casualty events. CDC has an integral role in strengthening State and local public health infrastructure to effectively respond to emergencies.

The Office of Public Health Emergency Preparedness (OPHEP) was established to direct the Department's efforts in preparing for, protecting against, responding to, and recovering from all acts of bioterrorism and other public health emergencies that could affect the civilian population. OPHEP serves as the focal point within HHS for these activities, directing and coordinating the development and implementation of a comprehensive HHS strategy. The measures described in this section are representative of HHS progress towards building the necessary infrastructure to respond to bioterrorist and other public health challenges.

PROGRAM 2A: FIELD FOODS PROGRAM
Food and Drug Administration (FDA)

Performance Measure: *Perform prior notice import security reviews on food and animal feed line entries considered to be at risk for bioterrorism and/or to present the potential of a significant health risk.*

The Field Foods Program promotes and protects the public's health by ensuring that the U.S. food supply is safe, sanitary, wholesome, and honestly labeled, and that cosmetic products are safe and properly labeled. As a result of the terrorist attacks of September 11, 2001, and the passage of the Bioterrorism Act of 2002, the FDA took on a food security/defense role to improve the protection of the nation's food supply, which is among the worlds safest.

The volume of all FDA-regulated imported shipments including food and animal feed has been rising steadily in recent years, and this trend is likely to continue. Between FY 2004 and FY 2005, FDA-regulated imports grew by 19 percent. In FY 2005 food and animal feed products comprised approximately 65 percent of the imported goods that FDA reviewed. To manage this ever-increasing volume, FDA uses risk management strategies to protect the public health.

Prior Notice Security Reviews are the most important counter-terrorism activity in the Field Foods Program. In FY 2007, FDA will continue to focus much of its resources on intensive prior notice import security reviews of products that pose the highest potential bioterrorism risks to the U.S. consumer and market. By FY 2007, FDA expects that the Prior Notice Center will have hired a permanent staff of Reviewers and Watch Commanders that will have achieved the training and gained the experience necessary to target additional threat parameters. The Prior Notice Center will receive feedback from import field exams and filer evaluations and begin targeting those individuals that continuously violate the law and commodities based on immediate and potential threats to the integrity and security of the intact food supply chain. In addition, broader surveillance of products imported from countries considered to be at a higher risk for terrorist activities can be incorporated into targeting goals. Strategies used to ensure effective targeting will include:

- Intelligence regarding countries at risk for terrorism;
- Intelligence regarding commodities susceptible to or exploited by terrorism;
- Intelligence specific to shipment or shipping entities;
- Information gleaned from Foreign and Domestic Establishment Inspection Reports that identify security breaches;
- Sample collection and analysis for counterterrorism;
- Prior Notice discrepancies reported during import field exams; and
- Filer evaluation field audits.

FDA anticipates that the measures that it uses to assess its success in monitoring the safety and security of imported products will continuously evolve as trade practices and information about risks change.

The prior notice requirement of the Bioterrorism Act became effective in December of 2003. In 2007, FDA expects to perform 60,000 prior notice reviews. In FY 2005, FDA achieved its goal by collaborating with the Department of Homeland Security's Customs and Border Protection to direct field personnel to conduct 86,187 intensive security reviews of prior notice submissions in order to intercept contaminated products before they entered the food supply. This exceeded the FY 2005 target by 48,187. In FY 2004, FDA collaborated with Customs and Border Protection to direct field personnel to hold and examine 20 suspect shipments of imported food; responded to 20,430 inquiries; and conducted 33,111 intensive reviews of prior notice submissions out of 6,294,821 in order to intercept contaminated products before they entered the food supply.

As FDA continues to develop its relationship with the Department of Homeland Security's Customs and Border Protection organization, practices, procedures and regulations may change that will result in changes in Prior Notice Security Review activities.

The import security reviews that are performed by the Prior Notice Center are performed on those prior notice submissions that are selected after intelligence, known risk factors and information available about the manufacturer, shipper, and consignee are applied to the prior notice submission data. The selection of candidates for security review is not related to the volume of submissions; they are selected on the basis of risk factors. If threats are reduced, then it is possible for the number of security reviews to decline. One possible circumstance might be the suspension of imports from a country or countries whose potential imports trigger many security reviews. Another possibility could be dramatically increased numbers of reviews because of newly identified risk factors. The estimate of the number of security reviews to be performed is simply an estimate based on the recent past. In today's risky environment, it may be well over or under, the number that will be performed. It is the quality of the targeting information and the quality of the review itself that provides the security, not the proportion of potential items selected for security review.

Performance Measure: Perform prior notice import security reviews on food and animal feed line entries considered to be at risk for bioterrorism and/or to present the potential of a significant health risk.

Year	Target	Result
2007	60,000	01/2008
2006	45,000	01/2007
2005	38,000	86,187
2004	Baseline	33,111

Data Source: Field Data Systems

Data Validation: ORA uses two main information technology systems to track and verify field performance goal activities: the Field Accomplishments and Compliance Tracking System (FACTS) and the Operational and Administrative System Import Support (OASIS). FACTS includes data on the number of inspections; field exams; sample collections; laboratory analyses; and, the time spent on each. OASIS, which is coordinated with U.S. Customs and Border Protection, provides data on what FDA regulated products are being imported as well as where they are arriving. It also provides information on compliance actions related to imports. FDA is currently developing the Mission Accomplishment and Regulatory Compliance Services (MARCS) system. MARCS will incorporate the capabilities of these two field legacy systems and include additional functionality.

Performance Budget Reference: FDA FY 2007 CJ, Pg. 312.

PROGRAM 2B: BIOTERRORISM HOSPITAL PREPAREDNESS PROGRAM

Health Resources and Services Administration (HRSA)

Performance Measure: *Percent of awardees that have developed plans to address surge capacity.*

A terrorist attack or other large-scale emergency could result in a demand for health care that could rapidly overwhelm the resources in a specific region. The National Hospital Preparedness program works to maximize surge capacity in the event of such an emergency. Surge capacity is the ability to evaluate and care for a markedly increased volume of patients. The requirement to develop plans to address surge capacity is based on the concept that improved outcomes can be achieved when critical components of preparedness are organized into a system of care.

Plans for surge capacity must address the following issues: (1) hospital bed capacity for adults and children; (2) the capability for isolation and decontamination; (3) appropriate staffing; (4) appropriate medical prophylaxis and treatment for hospital staff and their family members; (5) personal protective equipment; (6) capacity for trauma and burn care; (7) capacity for mental health care; (8) communications and information technology; and (9) hospital laboratory connectivity and capacity.

The FY 2007 target measure is for 100 percent of grant recipients to have developed plans to address surge capacity.In FY 2005, 100 percent of Hospital Preparedness program awardees had developed surge capacity plans, meeting the target. This represented an increase from 89 percent in FY 2004. In the future, the program will track various aspects of the implementation of these plans.

A PART review of the Bioterrorism Hospital Preparedness Program was conducted for the FY 2005 budget; the program received a rating of Results Not Demonstrated. The assessment found that the purpose and importance of this effort are clear and that the effort is well coordinated with other Federal preparedness efforts. The review also noted that the program has not yet demonstrated results due its relative newness and the inherent difficulty of measuring preparedness against an event that does not regularly occur. The program notes, in this context, the added challenge of measuring the relatively new and evolving concept of preparedness.

Performance Measure: Percent of awardees that have developed plans to address surge capacity.

Year	Target	Result
2007	100%	09/2007
2006	100%	09/2006
2005	100%	100%
2004	90%	89%
2003	Not Applicable	59% (estimated baseline)

Data Source: Grantees' semi-annual progress reports and continuation applications.

Data Validation: Validated by project officers through review of plans and site visits.

Performance Budget Reference: HRSA FY 2007 CJ.

The assessment recommended that the program work with State and local representatives to ensure that performance information will be available. This work is underway. The additional annual performance measures developed during the PART review very early in the life of the program are no longer applicable as they are inconsistent with the evolution of the program and the elements identified in the National Preparedness Goal and its companion documents. They also fail to reflect the direction and focus of the current preparedness efforts. Given this, the Hospital Preparedness Program has reexamined the specific elements of these measures and will propose modifications, in consultation with DHHS and the Administration, to improve the program's ability to monitor performance in the future.

As the Nation, and more specifically the NBHPP, moves to support the National Preparedness Goal, which includes medical surge as one of the four specified capability priorities for the country, certain levels of responsibility will be assigned to local, state, and regional governments to develop and maintain. In FY 2007 the program will continue to focus heavily on the following areas of capability required to perform assigned missions and tasks: personnel, planning, organizational leadership, equipment and systems, training and exercises, evaluations, and corrective actions. Further, promotion of interstate regional planning will be emphasized with more focus on exercises, drills and after action reports (to confirm the competence of healthcare providers).

STRATEGIC GOAL 2C: TERRORISM PREPAREDNESS AND EMERGENCY RESPONSE PROGRAM

Centers for Disease Control and Prevention (CDC)

Performance Measures:

100 percent of State public health agencies are prepared to use material contained in the SNS as demonstrated by evaluation of standard functions as determined by CDC.

100 percent of State public health agencies improve their capacity to respond to exposure to chemicals or category A agents by annually exercising scalable plans and implementing corrective action plans to minimize any gaps identified.

Following are the CDC preparedness goals:

1. **Prevent:** Increase the use and development of interventions known to prevent human illness from chemical, biological, radiological agents and naturally occurring health threats.
2. **Detect / Report:** Decrease time needed to classify health events as terrorism or naturally occurring in partnership with other agencies.
3. **Detect / Report:** Decrease time needed to detect and report chemical, biological, and radiological agents in tissue, food, or environmental samples that cause threats to the public's health.
4. **Detect / Report:** Improve the timeliness and accuracy of communications regarding threats to the public's health.
5. **Investigate:** Decrease time to identify causes, risk factors, and appropriate interventions for those affected by threats to the public's health.
6. **Control:** Decrease time needed to provide countermeasures and health guidance. Activities include distribution of materials from the Strategic National Stockpile (SNS).
7. **Recover:** Decrease time needed to restore health services and environmental safety to pre-event levels.
8. **Recover:** Improve long-term follow-up provided to those affected by threats.
9. **Improve:** Decrease time needed to implement recommendations from after-action reports. Activities include State and Local Readiness cooperative agreement and program services.

STRATEGIC NATIONAL STOCKPILE (SNS)

CDC, in *A Guidance for Preparedness, V 10.00*, describes 12 functions of SNS Preparedness required for the effective management and use of deployed SNS materiel. Based on these functions, State and local public health grantees are required to develop SNS Preparedness Plans detailing the performance of these functions during an emergency. In an effort to enhance grantee planning efforts, the SNS program maintains a staff of Program Services Consultants who provide ongoing technical advice and training assistance to grantees. The consultants also evaluate the grantee's level of

Performance Measure: 100% of State public health agencies are prepared to use material contained in the SNS as demonstrated by evaluation of standard functions as determined by CDC.

Year	Target	Result
2007	90% certified	12/2007
2006	80% certified	12/2006
2005	70% certified	76% (Exceeded)
2004	60% certified	72% (Exceeded)

Data Source: Completed SNS Assessment Tools, based on criteria outlined in A Guide for Preparedness, V 10.00.

Data Validation: All States are reassessed at least annually.

Performance Budget Reference: CDC FY 2007 CJ.

preparedness to receive, distribute and dispense SNS assets. As of December 2005, 76 percent (41/54) of the states and directly-funded cities have met the minimum standards for demonstrating preparedness to use SNS assets. The FY 2007 target is to achieve a level of 90 percent of grantees meeting the minimum standards.

State and Local Preparedness and Planning

In order for state and local public health agencies to test their capabilities for responding to bioterrorism, chemical exposures, and other public health emergencies, CDC recommends that response plans be tested regularly by staff participation in exercises and simulation drills. Lessons learned from both responses to real events and annual exercises can help identify gaps in preparedness planning and should result in improved public health responses.

Performance Measure: 100 percent of State public health agencies improve their capacity to respond to exposure to chemicals or category A agents by annually exercising scalable plans and implementing corrective action plans to minimize any gaps identified.

Year	Target	Result
2007	100%	12/2007
2006	100%	12/2006
2005	25%	94% (Exceeded)

Data Source: Self-reported data as part of required progress reports.

Data Validation: Plans for validation of self reported data are under development.

Performance Budget Reference: CDC FY 2007 CJ.

The FY 2005 target that 25 percent (at least 15) of states/territories/grantees conduct an exercise to evaluate their plans and response systems was exceeded with 94 percent (47/50) of State public health agencies exercising the plan for at least one of these priority agents. In future years, grantees will need to implement corrective actions within 90 days of identifying a deficiency through a drill, exercise, or real event. The FY 2007 target expects that 100 percent of grantees will meet requirements in these areas.

STRATEGIC GOAL 3

Increase the Percentage of the Nation's Children and Adults Who Have Access to Health Care Services

Highlighted Programs:

3a. Health Center Program (HRSA)

3b. National Diabetes Program (IHS)

3c. Medicare (CMS)

3d. Medicaid (CMS)

3e. State Children's Health Insurance Program (CMS)

HHS is committed to its many efforts aimed at increasing the percentage of the Nation's children and adults who have access to care and to expanding consumer choices. In FY 2007, the Department will continue to work hard to promote increased access to health care, especially for uninsured and underserved people and for those whose health care needs are not adequately met by the private health care system.

In support of this goal, HHS will continue to promote a wide variety of activities intended to increase access to health care; encourage the development of low-cost health insurance options, reduce health disparities, and to strengthen and improve health care services for targeted populations with special health care needs.

Over 34 HHS programs in six OPDIVs contribute to achieving this strategic goal. Five programs are highlighted in this strategic goal:

- HRSA's Health Centers Program: Provides regular access to high quality, family oriented, and comprehensive primary and preventive health care regardless of patients' ability to pay.
- Indian Health Service (IHS) National Diabetes Program: Works with communities to prevent and treat diabetes in American Indian/ Alaska Native people.
- Centers for Medicare and Medicaid (CMS) Medicare program: Helps pay medical bills for millions of aged and disabled Americans and has provided them with comprehensive health benefits.
- CMS' Medicaid program: Serves as the primary source of health care for a large population of medically vulnerable Americans, including poor families, the disabled, and persons with developmental disabilities requiring long-term care.
- CMS' State Children's Health Insurance Program (SCHIP): Stimulates enormous change in the availability of health care coverage for children, in coordination with Medicaid.

PROGRAM 3A: HEALTH CENTER PROGRAM
Health Resources and Services Administration (HRSA)

Performance Measure:

Increase the number of uninsured and underserved persons served by health centers.

Increase new and expanded health center sites.

The Health Centers program is a major component of America's health care safety net for the Nation's indigent populations. Expansion of this program, which is nearly 40 years old, is a Presidential initiative to increase health care access for those Americans who are most in need. Millions of Americans are uninsured and lack access to a regular source of health care. Health centers provide regular access to high quality, family-oriented, and comprehensive primary and preventive health care regardless of patients' ability to pay. The ultimate goals of the Health Centers program are to contribute to improvements in the health status of underserved and vulnerable populations and to contribute to the elimination of health disparities.

Growth in the number of persons served by health centers is an indicator of improved access to care. The projection is that the Health Centers program will serve 15.8 million persons in FY 2007. The Health Centers program served 13.1 million people in FY 2004, achieving more than 99 percent of its target even though it generally takes several years for newly established sites to become fully operational. The increase from 2003 to 2004 represents a growth of more than 700,000 additional persons served.

Performance Measure: Increase the number of uninsured and underserved persons served by health centers.

Year	Target	Result
2007	15.8 million*	08/2008
2006	14.6 million	08/2007
2005	14.0 million	08/2006
2004	13.2 million	13.12 million
2003	12.5 million	12.4 million
2002	11.75 million	11.32 million

Data Source: HRSA/BPHC Uniform Data System (UDS), based on data provided by grantees.

Data Validation: UDS data are validated through edit checks and onsite reviews.

Performance Budget Reference: HRSA FY 2007 CJ.

*The FY2007 target based on the President's budget request to Congress is subject to change based on the actual FY 2007 appropriation.

A critical element in expanding access to care for the Nation's most vulnerable populations is the establishment of new health center sites and the expansion of existing sites to provide required facilities, personnel and services, particularly in communities of greatest need. The target for FY 2007 is 302 new or expanded sites. In FY 2005, the Health Centers program funded 158 new or expanded sites, which exceeded the target.

Performance Measure: Increase new and expanded health center sites.

Year	Target	Result
2007	302*	10/2007
2006	121	10/2006
2005	153	158
2004	124	129
2003	180	188
2002	260	302

Data Source: HRSA/BPHC's Bureau of Health Care Delivery and Assistance Network (BHCDANET), which maintains data on health center sites that are included in the grantees' scope of project.

Data Validation: BHCDANET is an agency mainframe system with business rules to generate unique grantee and site identifiers and has hard code editing procedures. Site development is also monitored via OMB Circular A-133 audit reports.

Performance Budget Reference: HRSA FY 2007 CJ.

* The FY 2007 target based on the President's budget request to Congress is subject to change based on the actual FY 2007 appropriation.

A PART review of the Health Centers program was conducted in CY 2002. The program was rated Effective, the highest rating a program can achieve. The assessment found that the program purpose is clear, the program is designed to have a unique and significant impact, the program uses performance information to improve administrative and clinical outcomes, and the program is making progress in achieving its long-term outcome goals.

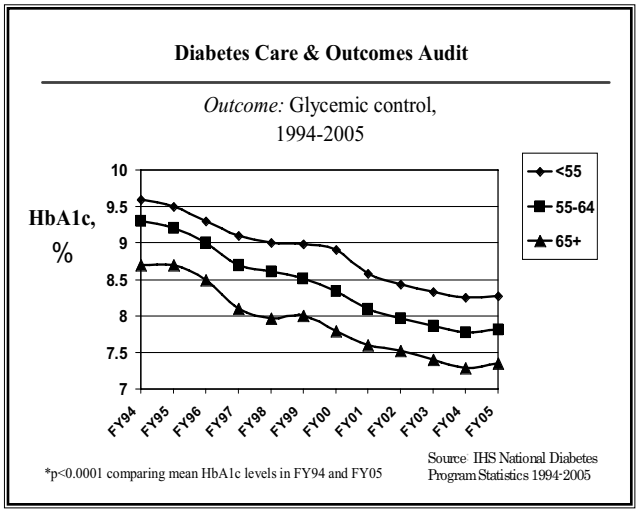
PROGRAM 3B: NATIONAL DIABETES PROGRAM
Indian Health Service (IHS)

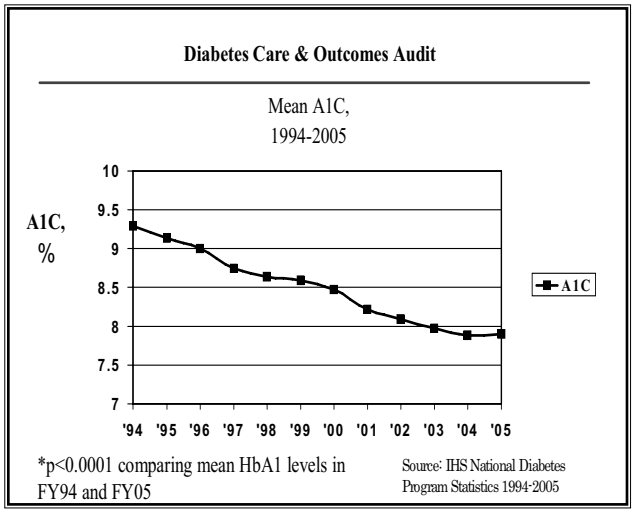
Performance Measure: *Address the proportion of patients with diagnosed diabetes that have demonstrated glycemic control at the ideal level (HbA1c< 7).*

The IHS Division of Diabetes Treatment and Prevention (DDTP) is an integral part of the IHS Hospitals and Health Clinics Program. The mission of the DDTP is to develop, document, and sustain a public health effort to prevent and control diabetes in AI/ANs. IHS currently has seven diabetes performance measures within its annual Performance Budget.

Glycemic control refers to how well blood sugars are controlled in a person with diabetes. It is measured with a blood test called the hemoglobin A1C (A1C). A lower A1C percentage indicates better blood sugar control. Keeping Hemoglobin A1C levels below 7 (ideal glycemic control) can slow or prevent the onset and progression of complications, including cardiac, eye, kidney, and nerve disease caused by diabetes.

The IHS Diabetes Care and Outcomes (DCO) Audit process divides these levels of glycemic control into percentage categories: "Ideal" (<7); "Good" (7.0-7.9); "Fair" (8.0-9.9); "Poor" (10-11.9); and "Very Poor" (>12), based on national diabetes care standards. The first graph illustrates IHS' ongoing ability to improve glycemic control in AI/AN populations (broken into age categories for patients under 55 years, 55 to 64 years and 65 years and older). The second graph illustrates improving glycemic control over time among the IHS population as a whole.





In FY 2007, IHS will maintain the 36 percent of patients with diagnosed diabetes that have demonstrated glycemic control at the ideal level (HgbA1C<7) based on the IHS DCO Audit. Since 1998, IHS has met the targets for this measure based on the IHS DCO Audit data. The FY 2005 indicator was to maintain the proportion of AI/AN patients with diabetes that have ideal glycemic control; IHS exceeded the target by two percent. IHS also met and surpassed the FY 2004 ideal glycemic control indicator by two percent.

IHS targets continue to be ambitious in overcoming the diabetes epidemic in AI/AN populations. There is a historical and projected annual increase in diabetes prevalence of four percent. Since 1997, the number of patients with diabetes served by the I/T/U system has increased by 45 percent, according to a review of diabetes program data by diabetes statisticians.

The elimination of diabetes-related health disparities that AI/AN patients experience depends on meeting the growing demand for treatment services, as well as identifying additional cost-effective preventive interventions.

The CY 2002 PART process included a review of the IHS Direct Federal Programs and the Hospital and Clinics Budget, where the diabetes funding resides; the program received a rating of Moderately Effective. The PART assessment focused attention on the continued importance of assuring valid and reliable performance data; thus, the diabetes measure has also been addressed in later PART reviews. It was included in both the Urban Indian Health Program and RPMS/IT PART reviews during the CY 2003 PART process. In addition, the CY 2004 Facilities PART and the CY 2005 Tribally Operated Health Facilities include the proportion of patients achieving ideal glycemic control as one of the program measures.

Performance Measure: Address the proportion of patients with diagnosed diabetes that have demonstrated glycemic control at the ideal level (HbA1c<7).

Year	Target	Result
2007	36%	1/2008
2006	36%	1/2007
2005	34%	36%
2004	32%	34%
2003	30%	31%
2002	30%	30%

Data Source: yearly IHS Diabetes Care and Outcome Audit.

Data Validation: Annual aggregation/comparison of data using CRS and Diabetes Audit results

Performance Budget Reference: IHS FY 2007 CJ

STRATEGIC GOAL 3c: MEDICARE
Centers for Medicare & Medicaid Services (CMS)

Performance Measures:

Implement the new Medicare Prescription Drug Benefit.

Improve Satisfaction of Medicare Beneficiaries With the Health Care Services They Receive

CMS is helping the Department meet its goal of expanding consumer choice and access to healthcare by implementing the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) which extends Medicare prescription drug coverage to Medicare beneficiaries. CMS is also collaborating with health care providers to improve the health status for Medicare beneficiaries and, through the survey and certification of providers, ensure the safety and quality of healthcare services and devices provided to beneficiaries. To inform beneficiaries of their benefits and choices within the Medicare program CMS administers comprehensive outreach and education programs including, regular and continuous surveys, complaint investigations and mediation with healthcare providers.

Performance Measure: Implement the new Medicare Prescription Drug Benefit.

Year	Target	Result
2007	1) Increase beneficiary awareness of the different features and options of the new drug benefit by through outreach and production of educational materials: a. Percentage of people with Medicare that know that people with Medicare will be offered/are offered prescription drug coverage starting in 2006 –50.9% b. Percentage of beneficiaries that know that the out-of-pocket costs will vary by the Medicare prescription drug plan – 54.1% c. Percentage of beneficiaries that know that all Medicare prescription drug plans will not cover the same list of prescription drugs – 29.3% 2) TBD (Note: FY 2007 operational goals will be identified in 07/2006 after baselines have been established.)	1) 09/2007 2) 09/2007
2006	1) Increase beneficiary awareness of the different features and options of the new drug benefit by 5% through outreach and production of educational materials: a. Percentage of people with Medicare that know that people with Medicare will be offered/are offered prescription drug coverage starting in 2006 – 49.4% b. Percentage of beneficiaries that know that the out-of-pocket costs will vary by the Medicare prescription drug plan – 52.5% c. Percentage of beneficiaries that know that all Medicare prescription drug plans will not cover the same list of prescription drugs – 28.4% 2) Implement a Part D Claims Data system, oversight system, and contractor management system.	1) 07/2007 2) 07/2007
2005	1) Develop and publish the Final Rule in the Federal Register with requirements for the new benefit. 2) Developmental. Baselines and future targets will be developed to measure Medicare's informational activities, including beneficiary awareness of different features of the new benefit.	1) Goal met. Final rule published 01/2005 2) Goal met. See FY 2006 Target
2004	Develop and Publish a Notice of Proposed Rulemaking in the Federal Register with requirements for the new benefit.	Goal met. Notice published 08/2004

Data Source: The data source is the NMEP Assessment Survey, which is a nationally representative survey of approximately 2,000 beneficiaries.

Data Validation: The questions on this survey have been extensively tested with Medicare beneficiaries and the survey has been tested for reliability and validity. The NMEP Assessment Survey is subject to verification typical of survey work, including data range checks and internal consistency checks, which are done electronically at the time the responses are entered in the Computer Assisted Personal Interview (CAPI) device.

Performance Budget Reference: CMS FY 2007 CJ. Pg. 205.

In 2003, Medicare received a rating of Moderately Effective in the PART process, in part because the program needed to be updated, including making prescription drugs part of the benefits model. Since that time, as a result of MMA, the Medicare program has taken steps to address program challenges identified in the PART, including implementing the new prescription drug benefit.

Performance Measure: Improve satisfaction of Medicare beneficiaries with the health care services they receive.

Year	Target	Result
2007	Collect data, set baselines/targets.	09/2007
2006	Refocused to capture MMA performance Develop survey to capture MMA measures	09/2006
2005	Collect (& share) data by the end of CY 2004 (in FY 2005): 1) MA Care: 93% 2) MC Specialist: 86% 3) FFS Care: 95% 4) FFS Specialist: 85%	1) MA data available 07/2006. 2) MA Specialist data available 07/2006. 3) FY 2004 FFS Care 92.0% 3) FFS Specialist: 86.9%
2004	Collect (& share) data by the end of CY 2004 (in FY 2005).	Goal met: data collected and shared.
2003	Collect (& share) data by the end of CY 2004 (in FY 2005).	Goal met: data collected and shared.
2002	Collect (& share) data by the end of CY 2004 (in FY 2005).	Goal met: data collected and shared.

Data Source: Consumer Assessment Health Plans Survey, using Medicare Advantage (MA) and fee-for-service (FFS) measures for access to care and access to specialist

Data Validation: The Medicare CAHPS are administered according to the standardized protocols as delineated in the CAHPS 2.0 Survey and Reporting Kit developed by the Agency for Healthcare Research and Quality (AHRQ). This protocol includes two mailings of the survey instruments to randomized samples of Medicare beneficiaries in health plans and geographic areas, with telephone follow-up of non-respondents with valid telephone numbers. CAHPS data are carefully edited and cleaned prior to the creation of composite measures using techniques employed comparably in all surveys. Both non-respondent sample weights and managed care-FFS comparability weights are employed to adjust collected data for differential probabilities of sample selection, under-coverage, and item response.

Performance Budget Reference: CMS FY 2007 CJ, Pg.200

As of January 2006, Medicare beneficiaries have access to a standard prescription drug benefit. People with limited assets and low income will receive a more generous benefit package. Data collection will begin in 2006 to monitor the effectiveness of the implementation phase.

One of CMS' ultimate goals is to assure satisfaction of its primary customer – the Medicare beneficiary. In 2006 and beyond, CMS will work to improve the already high satisfaction levels beneficiaries have with the Medicare program. CMS measures satisfaction using beneficiary responses to questions on the Medicare Consumer Assessment of Health Plan Survey (CAHPS) regarding access to care and specialists in both Medicare fee-for-service and Medicare Advantage. CMS will make modifications to the Medicare CAHPS to reflect MMA program changes, including measurement of experience and satisfaction with the care and services provided through the new Medicare Prescription Drug Plans as well as the Medicare Advantage and Medicare Fee-For-Service health plans. CMS will develop the revised survey instruments in FY 2006 with data collection to begin in FY 2007.

STRATEGIC GOAL 3D: MEDICAID
Centers for Medicare & Medicaid Services (CMS)

Performance Measure: *Improve the Quality of Health Care for Medicaid Beneficiaries through Demonstrated Enhancements to Overall State Quality Strategies.*

The Medicaid program directly supports HHS Strategic Goal 3 by providing the primary source of health care coverage for a large population of medically vulnerable Americans, including poor families, people with disabilities, and people with long-term care needs. Additionally, many other low-income uninsured individuals, who are not otherwise eligible for Medicaid, receive coverage through the use of waivers. In FY 2005, there were 49.1 million individuals enrolled in Medicaid, including those enrolled through the use of waivers.

In 2005, CMS released a Quality Roadmap with a vision for the "right care for every person every time" and a detailed strategy to improve the quality of care for Medicaid beneficiaries. To complement this vision, CMS developed a new performance measure to improve Medicaid beneficiary access to quality health care. The measure, to improve access to quality health care for Medicaid beneficiaries through demonstrated enhancements to overall State quality strategies, supports HHS Strategic Goal 3. This new quality improvement goal will evaluate State quality strategy assessments and use findings to improve efficiency and effectiveness in State quality improvement activities. In FY 2007, CMS will provide technical assistance to a minimum of five States with Managed Care Organizations or Prepaid Inpatient Health Plans. The technical assistance is intended to guide States through the process, including enhancing State Quality Strategies, through participation in activities such as regional collaboratives, and improving performance reporting.

Performance Measure: Improve the Quality of Health Care for Medicaid Beneficiaries through Demonstrated Enhancements to Overall State Quality Strategies.		
Year	**Target**	**Result**
2007	Following technical assistance from CMS, demonstrate that a minimum of five states with Managed Care Organizations (MCO) and/or Prepaid Inpatient Health Plans (PIHP): (a) Submit enhancements to State Quality Strategies, and (b) Demonstrate improved beneficiary performance reporting.	02/2008
Data Source: Developmental. States report quality improvement efforts via several vehicles including state quality improvement strategies (CFR 438.204 Subpart D), External Quality Review Organizations (EQRO) Reports (CFR 438.310-438.70 Subpart E), program evaluation reports, and performance measurement reports. A combination of these data sources will be analyzed, when available and appropriate, to ensure a comprehensive review of state quality improvement activities.		
Data Validation: Developmental. CMS has developed standardized templates and protocols for review and validation of quality improvement strategies, selected EQRO requirements, and program evaluations. The elements of the template are stored electronically and help to facilitate objective and consistent reviews between the states.		
Performance Budget Reference: FY 2007 CJ, Pg 270.		

STRATEGIC GOAL 3E: STATE CHILDREN'S HEALTH INSURANCE PROGRAM

Centers for Medicare & Medicaid Services (CMS)

Performance Measure: *Improve Health Care Quality Across SCHIP.*

In direct support of HHS Strategic Goal 3, SCHIP is the largest expansion of health insurance coverage for children in more than 30 years. Its implementation has improved access to health care and the quality of life for millions of vulnerable children under 19 years of age. SCHIP was created through the Balance Budget Act of 1997 and was authorized through FY 2007. Under title XXI of the Social Security Act, States are given the option of creating their SCHIP program by expanding Medicaid (title XIX) coverage, setting up a separate SCHIP program, or creating a combination of the two. To date, SCHIP has 6.9 million beneficiaries enrolled and continues its focus on increasing healthcare enrollment for low income children.

The performance measure related to improving the quality of health care across the SCHIP program supports HHS Strategic Goal 3 by continuing to focus on the number of children who have access to quality healthcare. To focus on improving access to quality healthcare, CMS began collecting SCHIP performance data through State annual reports in FY 2003. Using this data, CMS is providing technical assistance to States on measurement methodologies and appropriate targets for SCHIP core measures to improve children's access to quality healthcare. Through the analysis of these reports, CMS has successfully tracked State progress since FY 2003. In order to increase the value of these reports for FY 2007, CMS will revise the FY 2006 annual report template to include state quality improvement effort data.

Performance Measure: Improve Health Care Quality Across SCHIP.

Year	Target	Result
2007	Revise FY 2006 Annual report template to reflect states' quality improvement efforts.	12/2006
2006	Improve reporting by States on core performance measures in order to have at least 25% of States reporting at least one core performance measure in FY 2004 Annual Report.	06/2006
2005	Continue to collect core performance measurement data from States through the State annual reports; Use the new automated State Annual Report Template System (SARTS) to analyze and evaluate performance data; and Provide technical assistance to States on establishing baselines, measurement methodologies, and targets for SCHIP core measures.	Goal met. Performance data has been collected and analyzed in SARTS. Technical assistance has been provided
2004	Refine data submission, methodological processes, and reporting; Produce 2002 performance measures in standardized reporting format; and Collect 2003 data (baseline) from States.	Goal met. Data collection process refined and FY 2003 data collected.
2003	To begin working on States on the PMPP; Report on results of the meeting with States and identify a timeline for implementing recommendations; Identify a strategy for improving health care delivery and/or quality, and specify measures for gauging improvement; Initiate action steps for implementing recommendations; and Begin to implement core SCHIP performance measures.	Goal met. Identified a timeline for implementing recommendations and a strategy for improving health care delivery and/or quality, specified measures for gauging improvement and began to implement core SCHIP performance measures.

Data Source: Developmental. Beginning in FY 2003, CMS began collecting SCHIP performance measures through the SCHIP annual reports. In addition, CMS created an automated web-based system, SARTS, which allows States to input and submit their annual reports to CMS via the internet. This system allows CMS to better analyze data submitted by States, specifically the progress States are making toward meeting their individual SCHIP goals.

Data Validation: Developmental. CMS will monitor performance measurement data related to the SCHIP core performance measures through SARTS. In addition, State performance data submitted through SARTS will be monitored to assure that individual State goals are consistent with the approved Title XXI SCHIP State plan.

Performance Budget Reference: FY 2007 CJ, Pg. 280

STRATEGIC GOAL 4

Enhance the Capacity and Productivity of the Nation's Health Science Research Enterprise

Highlighted Programs:

4a. Knowledge Base on Chemical Effects in Biological Systems (NIH)

HHS recognizes the important role research plays in improving the Nation's health. As a result, many of the strategies that HHS has identified in achieving its other strategic goals incorporate a research base. This goal, therefore, focuses on creating the underlying knowledge and strategies that improve and maintain the research infrastructure that produces advances in health science.

HHS commitment to enhancing the capacity and productivity of the Nation's health science research enterprise is demonstrated, for example, by developing the knowledge base on Chemical Effects in Biological Systems (CEBS). Investment in this research will provide important information for identifying toxic substances in the environment, and help to treat people at the greatest risk of diseases caused by environmental pollutants or toxicants.

Approximately four HHS programs in three OPDIVs contribute toward achieving this strategic goal. One program is highlighted in this strategic goal.

HHS places a high priority on improving the coordination, communication, and application of health research results. Strategies to meet this goal include:

- Provide for easy access by academia and industry to HHS databases and findings from HHS research, with appropriate privacy and confidentiality protection.
- Expand the use of electronic technology and media channels to gather and transfer research information to researchers, practitioners, and the public.
- Establish quality standards for the dissemination and strategic application of consumer/communication research findings.
- Establish partnerships with health professional associations, industry groups, patient representatives, community groups, disability groups, and purchasers of care to more widely disseminate research findings.
- Support "implementation research" to determine how innovative, effective interventions can be implemented in actual settings and populations, including the means to reach diverse communities.
- Ensure that consumer research, demonstration, and evaluation results are communicated effectively across HHS agencies and to all decision makers.
- Support development of data-based quality of care and outcome measurement systems to track adoption of evidence-based practices.

PROGRAM 4A: KNOWLEDGE BASE ON CHEMICAL EFFECTS IN BIOLOGICAL SYSTEMS

National Institutes of Health (NIH)

Performance Measure: *By 2012, develop a knowledge base on chemical effects in biological systems using a systems toxicology or toxicogenomics approach.*

A new scientific field, toxicogenomics, is evolving to examine how chemical exposures disrupt biological processes at the molecular level. Toxicogenomics involves the collection, interpretation, and storage of information about gene and protein activity in order to identify toxic substances in the environment, and to help treat people at the greatest risk of diseases caused by environmental pollutants or toxicants. Because the pattern of regulation of various genes is different for different chemicals, scientists hope that these characteristic "signatures" will be useful in classifying exposure to these chemicals and other stressors by its biological activity. This information will provide a means of potentially predicting effects on human health from chemicals about which little is known. To enable this predictive capability, NIH is establishing a knowledge base on Chemical Effects in Biological Systems (CEBS), which will contain data on global gene expression, protein expression, metabolite profiles, and associated chemical/stressor-induced effects in multiple species.

CEBS will build the capacity for public electronic sharing of toxicogenomics data and information, making this data fully searchable and downloadable. Also, it will include traditional toxicology/ pathology data. This capability provides a way to use these very different types of data to estimate animal toxicity as well as to determine safe exposure levels in people. The information generated by CEBS can be used by research scientists, regulatory agencies like EPA and FDA, pharmaceutical companies, and the chemical industry. In order to insure maximum utility for these disparate potential users, CEBS is fully compliant with existing standards for microarray datasets as well as standards for the regulatory submission (FDA) of non-clinical (animal toxicology) data using the SEND format. This format enables pharmaceutical firms to transmit toxicology data to the FDA from their toxicology databases with a minimum of modifications.

Performance Measure: By 2012, develop a knowledge base on chemical effects in biological systems using a systems toxicology or toxicogenomics approach.		
Year	**Target**	**Result**
2007	Enhance electronic sharing of 'omics and biology endpoint data.	02/2008
2006	Enhance the CEBS to allow the capture and integration of transcriptomics, proteomics, and toxicologic data for the same compound.	02/2007
2005	Create and provide public access to a global molecular expression and toxicology/pathology database of both chemicals found in the environment and drugs that have an effect on biological systems (CEBS), featuring simple query download capability.	CEBS versions 1.5 and 1.6 have been made available to the public. These programs provide simple query download capability of global molecular expression and toxicology/pathology data on a select number of studies of chemicals found in the environment and drugs that have an effect on biological systems.
2004	Create the capability to import, export, and link molecular expression data by extending the Chemical Effects in Biological Systems (CEBS) database object model to include toxicology/pathology fields, and by creating a data portal that will load toxicology data.	CEBS now has a data portal that loads toxicology data. CEBS can import, export, and link molecular expression data to toxicology/pathology fields.
2003	Launch a pilot prototype database project to test the design and implementation of the knowledge base components and system architecture.	ProtoCEBS launched, tested, and implemented.
Data Source and Validation: CEBS web site at http://cebs.niehs.nih.gov/.		
Performance Budget Reference: NIH FY 2007 CJ, Pg. 142-144 http://nihperformance.nih.gov		

In FY 2007 CEBS will seek to enhance electronic sharing of 'omics (suffix refers to the study of a system of biomolecules, e.g. proteomics, transcriptomics) and biology endpoint data. The success of this measure will allow the ability to explore/align relevant portions of disparate experimental datasets based on response. Various data sets are

being integrated and an interface built to upload metabonomics data. The first step will be to integrate molecular expression with histopahologic outcomes (including images) for animal subjects exposed to chemicals/stressors. Then, standard anatomy and pathology onotologies will be incorporated. An image server will be built to enable an indexed query capability of pathology phenotype. The system will enable retrieval and cross domain (omics and toxicology/pathoplogy) computational evaluation of multiple studies of chemical stressors. If successful, scientists will have the capability to explore and align experimental datasets based on response (e.g., critical dose range). This component progresses towards developing a system that can provide a means of potentially predicting the effects on human health from chemicals.

In FY 2005, versions 1.5 and 1.6 of CEBS were made available to the public on the CEBS website (http://cebs.niehs.nih.gov). This program provides simple query download capability of global molecular expression and toxicology/pathology data on a select number of studies of environmental chemicals and drugs. Version 2.0 of CEBS is now being developed. This version of CEBS will capture much more detail of individual studies, e.g., type of diet, room temperatures, light/dark cycle, as well as housing many more study results. Currently, staff is defining the content and functionality of each page needed for this more robust toxicogenomics database.

The 2003 and 2004 annual targets for this goal were also met. In 2003, CEBS launched a pilot prototype database project to test the design and implementation of the database components and system architecture. In 2004, CEBS created the capability to import, export, and link molecular expression data by extending the CEBS database object model to include toxicology/pathology fields and by creating a data portal that will load toxicology data.

STRATEGIC GOAL 5
Improve the Quality of Health Care Services

Highlighted Programs:

5a. Medical Product Surveillance Network (FDA)

5b. Prevention Portfolio (AHRQ)

Improving the quality of life in the United States includes improving the quality of the health care services that individuals receive by reducing medical errors, improving consumer and patient information, and accelerating the development and use of electronic health information. To achieve this goal, HHS will continue implementation of a variety of strategies designed to improve the delivery of health care services. These strategies include the development and dissemination of evidence based practices, information systems, new technologies for the home and clinical setting, and improved reporting systems for medical errors and adverse events.

Health quality improvement at HHS also means translating new knowledge of effective health services into strategies, educational tools, and information to help clinicians and health care policy makers improve health care quality. HHS will work to expand provider networks to disseminate health care quality information, enabling consumers to make informed choices.

HHS will provide leadership to promote the development of a national health information infrastructure that takes advantage of the most current technology available. This will involve attention to the secure and confidential treatment of health information, adoption of national data standards, and research on the applications of a national health information infrastructure that informs consumers, patients, professionals, and other decision makers alike.

Over five HHS programs in five OPDIVs contribute to achieving this strategic goal. Two programs are highlighted in this strategic goal including FDA's Medical Product Surveillance Network and the Agency for Healthcare Research and Quality's (AHRQ) Prevention Portfolio.

PROGRAM 5A: MEDICAL PRODUCT SURVEILLANCE NETWORK
Food and Drug Administration (FDA)

Performance Measure: *Expand actively participating sites in MedSun Network.*

The FDA Modernization Act (FDAMA) mandates that FDA replace universal user facility reporting with the Medical Product Surveillance Network (MedSun), a network of user facilities that together will provide a representative profile of reports from major medical device product users such as hospitals. When fully implemented, MedSun will serve as an advance warning system for device problems and a laboratory for research and two-way communication between FDA and the user-facility community. Furthermore, MedSun will improve patient safety through recognition and management of use-related errors and offer feedback to manufacturers to improve device design.

MedSun is designed to improve FDA decision making about device problems by generating more useful and diverse reports from trained, engaged reporters. The program collects reports on deaths and serious injuries associated with the use of medical devices. Participating facilities are also highly encouraged to submit reports about close calls, which allow FDA to evaluate a device issue before patient injury occurs. Better information allows timelier signal detection and enhances FDA's ability to analyze and react to problems. A key component of MedSun is to offer easily accessible information related to safe device use. MedSun participants receive a continuous stream of feedback including newsletters, educational materials, publications and other information related to patient safety and device use. In 2006, an FDA MedSun web site will be developed so that this feedback, as well as other important device safety information learned through the MedSun system may be publicly available.

Performance Measure: Expand actively participating sites in MedSun Network

Year	Target	Result
2007	Expand activily participating site in the MedSun Network to 76%	01/2008
2006	Expand activily participating site in the MedSun Network to 71%“	01/2007
2005	Expand MedSun Network to 350 facilities	354 facilities
2004	Expand MedSun Network to 240 facilities	299 facilities
2003	Expand MedSun Network to 180 facilities	206 facilities
2002	Expand MedSun Network to 80 facilities	80 facilities

Data Source: CDRH Adverse Events Reports

Data Validation: FDA's adverse event reporting system's newest component is the Medical Device Surveillance Network, MedSun program. MedSun is an initiative designed both to educate all health professionals about the critical importance of being aware of, monitoring for, and reporting adverse events, medical errors and other problems to FDA and/or the manufacturer and; to ensure that new safety information is rapidly communicated to the medical community thereby improving patient care.

Performance Budget Reference: FDA FY 2007 CJ, Pg. 357.

In FY 2005, FDA increased the number of facilities in the MedSun network to 354, thus completing the network. In FY 2006 and FY 2007, FDA will turn its focus to ensuring active participation (at least 1 report submitted a year by each site). In FY 2007, FDA will seek to expand the percentage of actively participating sites in the MedSun network to 76%. Active participation in the network will increase the number of reports and improve the likelihood that FDA will reduce device-related medical errors. Moreover, this will provide an advanced warning system among the facilities in the network and create a two-way communication channel between FDA and the user-facility community.

FDA plans to use the following strategies to accomplish this:

- FDA is currently piloting the use of 'Regional Representatives' to travel to the MedSun hospitals and work with their staff to encourage event reporting as well as solicit feedback for improvements to the system.
- FDA is currently piloting two new educational tools designed to increase device-problem reporting within facilities, and then encourage the facilities to submit those reports to MedSun. Based on the success of these pilot programs, FDA will distribute these tools throughout the MedSun network and provide special follow-up calls and visits to non-reporting sites.
- FDA is planning to add regional meetings to its current annual Users' Conference. It is anticipated that these meetings will promote best practices with medical devices as well as generate increased reporting. FDA will make special overtures to non-reporting sites to encourage them to attend these regional meetings. FDA will begin implementing regional meetings in FY 2006.

FDA will continue to recruit additional facilities to replace existing facilities that have decided to place a low priority on participating in this voluntary network. This will increase the overall effectiveness of the system while holding the total number of facilities to approximately 350, which FDA believes is the optimum size.

Some of the external factors that will influence the success of the MedSun program are awareness of hospital staff in recognizing medical device problems, fear that the hospitals might face legal action due to reporting an adverse event, and the burden of submitting reports. MedSun will minimize these factors by training hospital staff in the recognition and reporting of medical device problems, assuring reporting confidentiality, minimizing the burdens of participation, and providing timely feedback on device safety issues including monthly newsletters, clinical engineering audio-conferences, device safety exchanges, and surveys on high-profile safety concerns.

PROGRAM 5B: PREVENTION PORTFOLIO
Agency for Healthcare Research and Quality (AHRQ)

Performance Measure: *Improve the timeliness and responsiveness of the United States Preventive Services Task Force (USPSTF) to emerging needs in clinical prevention.*

The Prevention Portfolio conducts comprehensive assessments of a wide range of preventive services including screening tests, counseling activities, immunizations, and preventive therapies. The United States Preventative Services Task Force (USPSTF) is a vital component of the Prevention Portfolio. The overall goal of the USPSTF is to provide evidence-based recommendations relevant to primary care providers. The Task Force works to improve the effectiveness and efficiency of healthcare delivery by promoting patient safety and by providing evidence-based recommendations for essential and non-essential clinical preventive services. One of the three overarching measures of success for the USPSTF is to improve the timeliness and responsiveness to emerging needs in clinical prevention. These needs include diseases that often are preventable, such as heart disease, diabetes, some cancers, and HIV/AIDS which result in premature deaths every year. By providing timely knowledge of clinical prevention, wider access and increase use of effective health care services is possible and thus could reduce health care costs.

In FY 2007, AHRQ will begin to decrease by 10% the number of USPSTF recommendations that are five years or older to ensure that recommendations remain current within National Guidelines Clearinghouse standards. In FY 2005, AHRQ worked to establish baseline measures for timeliness and responsiveness to the emerging needs of clinicians. AHRQ held stakeholder meetings to identify which recommendations were effective and what tools were needed to improve their quality and usability.

Performance Measure: Improve the timeliness and responsiveness of the United States Preventive Services Task Force (USPSTF) to emerging needs in clinical prevention.

Year	Target	Result
2007	Decrease by 10% the number of USPSTF recommendations that are five years or older.	12/2007
2006	Increase the number of annual topics reviewed by the task force by 10%.	12/2007
2005	Establish baseline measures for timeliness and responsiveness.*	Released 9 recommendations 78% current within National Guideline Clearinghouse (NGC) standards 100% of guidelines related to IOM priority areas for preventive care current with NGC standards Developed new topic criteria, submission, review, and prioritization processes with new USPSTF topic prioritization workgroup

Data Source: Two stakeholder meetings, an expert panel, and 4 clinician focus groups were conducted. The outcomes for these meetings identified what types of preventive services are being implemented and current barriers to further implementation. These qualitative sources of data assisted in determining best practices for delivering clinical preventive services as well as the quality of services being delivered. FY 2005 focused on the outcome measures to asses the quality and quantity of preventive services delivered. These measures focus on AHRQ's National Health Quality Report (NHQR) and Disparities Report (NHDR). These reports are composed of measures from multiple databases (i.e., Medical Expenditure Panel Survey (MEPS), Healthcare Cost and Utilization Project, Consumer Assessment of Health Plans.

Data Validation: Qualitative data sources (Stakeholder meetings, expert panels and focus groups) were conducted and synthesized by outside contractors. Established methodology for interpreting qualitative data was used. Results were presented at peer-reviewed scientific meetings. As a result, the process and findings were validated by outside stakeholders. Quantitative data sources (NHQR and NHDR). AHRQ annually produces the NHQR and NHDR as legislated by Congress. These reports are comprised of multiple databases supported by AHRQ. Thus the data undergoes internal review processes associated with the individual database as well as a global review as an annual report. AHRQ staff along with external partners review the measures and the validity of measures periodically throughout the year. In addition, the final versions of the NHQR and NHDR undergo Federal partner review as well as Departmental review.

Performance Budget Reference: AHRQ FY 2007 CJ.

* This is a new measure that was developed in FY 2005. Data is not applicable for FY 2002-2004.

The portfolio was directed to develop both print and electronic forms of the recommendations. As a result, AHRQ released a clinical pocket guide work and began working on the expansion of a PDA as a clinical decision-making tool.

In FY 2006, AHRQ is working to increase the number of annual topics reviewed by the task force by 10 percent. To date, the USPSTF has reviewed over 70 topics in the area of primary and secondary clinical prevention that address issues of screening, counseling, and chemoprophylaxis. Moreover, the Task Force has eliminated its backlog of topics, as evidenced by the release of 20 new recommendations. It continues to engage primary clinicians to address the situation where there is insufficient evidence for the Task Force to make a recommendation. AHRQ continues to collaborate with other Federal agencies to shape research agendas in the area of clinical prevention by facilitating the communication of these research gaps directly to funding agencies.

STRATEGIC GOAL 6

Improve the Economic and Social Well-Being of Individuals, Families, and Communities, Especially Those Most in Need

Highlighted Programs:

6a. Temporary Assistance for Needy Families (ACF)

6b. Aging Services Program (AoA)

HHS promotes and supports interventions that help empower disadvantaged and distressed individuals, families, and communities to improve their economic and social well-being. To achieve this strategic goal, HHS supports targeted efforts to increase the independence and stability of low-income families, people with disabilities, older Americans, Native Americans, victims of domestic violence, refugees, and distressed communities. HHS will also continue to support community and faith-based organizations that provide services to individuals and communities in need.

Approximately thirteen HHS programs in two OPDIVs contribute to achieving this strategic goal. Two programs are highlighted under this strategic goal including the Administration for Children and Families' (ACF) Temporary Assistance for Needy Families program and Administration on Aging (AoA) Aging Services Program.

STRATEGIC GOAL 6A: TEMPORARY ASSISTANCE FOR NEEDY FAMILIES

Administration for Children and Families (ACF)

Performance Measure: *Increase the percentage of adult TANF recipients/former recipients employed in one quarter that were still employed in the next two consecutive quarters.*

The purposes of the Temporary Assistance for Needy Families (TANF) program, Title IV-A of the Social Security Act, support HHS Strategic Goal 6.1. TANF provides assistance to needy families; reduces dependency by promoting job readiness, employment, and marriage; prevents and reduces out-of-wedlock pregnancies; and encourages the formation and maintenance of two-parent families. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), which established TANF, dramatically changed the nation's welfare system into one that requires employment while time-limiting assistance. States, territories, and tribes each receive a block grant allocation with a requirement for states to maintain a historical level of state spending for welfare and other services for low-income families known as Maintenance of Effort. The block grant covers benefits, administrative expenses, and services. States, territories, and tribes determine eligibility and benefit levels as well as services provided to needy families.

The Deficit Reduction Act of 2005 reauthorizes the TANF program for five years. This legislation strengthens the current work requirements to ensure that adult TANF recipients are engaged in work or activities leading to employment. It also contains recalibration of the caseload reduction credit, and eliminates the High Performance Bonus.

The performance measure on job retention supports HHS Strategic Goal 6 by encouraging employment stability for those most in need and thus improving their economic and social well-being. The job retention target for FY 2007 is 62 percent. ACF attained a job retention rate of 59 percent in FY 2004, falling short of the target of 68 percent. When setting the 68 percent target, ACF did not take into consideration the dampening effect of the caseload reduction credit, which significantly reduced state work participation rate targets and thus reduced state incentive for moving TANF recipients into employment. Results for previous years were similarly impacted. The revised targets for 2006 and 2007 were set in the PART process. ACF will re-evaluate the performance measures and targets to reflect the revised policies in the Deficit Reduction Act of 2005.

Performance Measure: Increase the percentage of adult TANF recipients/former recipients employed in one quarter that were still employed in the next two consecutive quarters.

Year	Target	Result
2007	62%	10/2008
2006	61%	10/2007
2005	68%	10/2006
2004	68%	59%
2003	68%	59%
2002	65%	59%

Data Source: Performance data for this measure is calculated using the National Directory of New Hires (NDNH).

Data Validation: Beginning with performance in FY 2001, the employment measures above – job entry, job retention, and earnings gain – are based solely on performance data obtained from the National Directory of New Hires (NDNH). Data are updated by states, and data validity is ensured with normal auditing functions for submitted data. Previous to use of the NDNH, states had flexibility in the data source(s) they used to obtain wage information on current and former TANF recipients under HPB specifications for performance years FY 1998 through FY 2000. ACF moved to this single source national database (NDNH) to ensure equal access to wage data and uniform application of the performance specifications. Performance achieved for FY 2001 and 2002 may have been affected by this change in data source.

Performance Budget Reference: ACF FY 2007: CJ, Pg.M-6

PROGRAM 6B: AGING SERVICES PROGRAM
Administration on Aging (AoA)

Performance Measure: *Increase the number of severely disabled clients who receive home-delivered meals.*

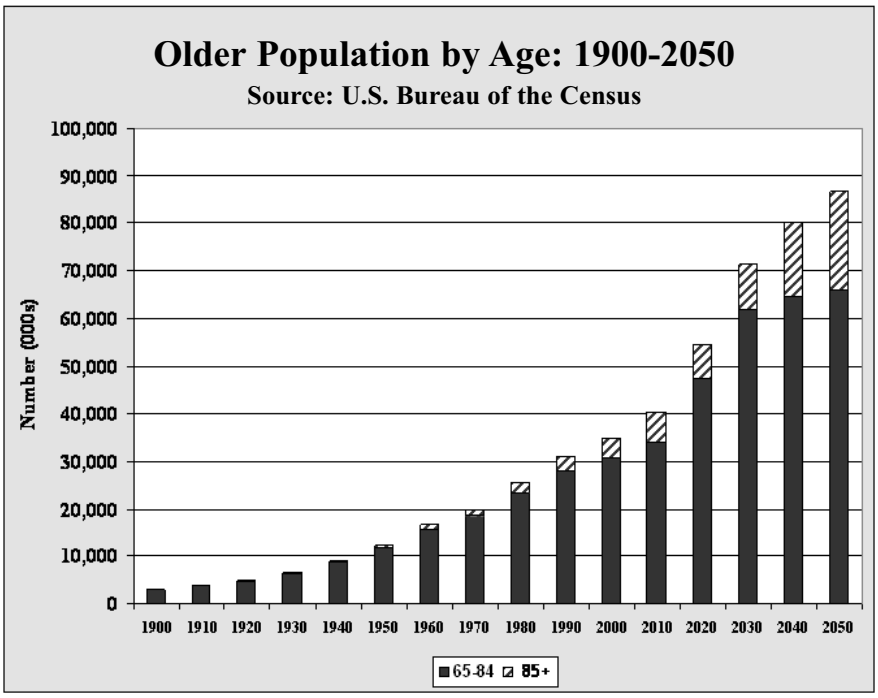
The Aging Services Program of the Administration on Aging (AoA), which encompasses all AoA programs, provides grants to states, tribal organizations, and other community service providers. Together these entities comprise the National Aging Services Network, which makes comprehensive supportive services available to vulnerable elderly individuals and their family caregivers. These services help to keep America's rapidly growing older population healthy, secure and independent in the community, where they prefer to reside. AoA programs, for a fraction of the cost of institutional care, are helping families to keep their loved ones at home for as long as possible. These services complement existing medical and health care systems and support some of life's most basic functions: food for the undernourished; transportation for the immobile; respite and counseling for caregivers; and personal care to those who need assistance getting in and out of bed, feeding and bathing themselves.

Increasing the number of severely disabled clients who receive home and community-based services from AoA and the National Aging Services Network is one of AoA's four targeting measures. Targeting measures and the indicators associated with them – while supporting HHS' strategic goals – complement AoA's efficiency and client assessment measures, in that they ensure that AoA and the National Aging Services Network focus services specifically on the most vulnerable of the elder populations. The targeting mechanism allows AoA to discourage service providers from simply channeling resources to and reporting on the easy-to-serve clients to give the appearance of improved efficiency and quality performance while the hardest-to-reach and often the neediest go wanting. Instead, AoA and the aging network measure how well they serve those who are at most risk of institutionalization: the disabled, poor, and rural residents.

Performance Measure: Increase the number of severely disabled clients who receive home-delivered meals.		
Year	**Target**	**Result**
2007	350,000 (Base + 25%)	02/2008
2006	322,000 (Base + 15%)	02/2007
2005	302,000 (Base + 8%)	02/2006
2004	291,200 (Base + 4%)	293,500
2003	Baseline: 280,000	New in FY 04
Data Source: State Program Report (SPR)		
Data Validation: For description of data validation, see AoA's FY 2007 CJ, pg.90.		
Performance Budget Reference: AoA FY 2007 CJ, pg. 79.		

This measure of severely disabled clients receiving selected home and community-based services was new in FY 2005 and AoA expects to increase severely disabled clients served from our FY 2003 base of 280,454. AoA has established ambitious performance targets for this measure; projecting an eight percent increase in FY 2005; a 15 percent increase in FY 2006 and a 25 percent in FY 2007. As efforts to rebalance the provision of long-term services continue, with greater emphasis on home and community-based care, the National Aging Services Network will demonstrate its successful contribution to rebalancing by serving increasing numbers of disabled or frail older persons. The data that support this performance measure are collected in AoA's annual national surveys of aging network clients.

AoA's Community-Based Services Program, which constitutes over 90 percent of the AoA Aging Services Program as a whole, was subject to a PART review during the CY 2002 budget formulation process. During CY 2003, AoA was reassessed under an expanded PART review, covering the entire Aging Services Program and received a rating of Moderately Effective. AoA achieved the improved score through enhancements to its strategic plan, the development of efficiency measures, and the assignment of ambitious performance targets, such as the one for serving older persons who are severely disabled. AoA has continued to make improvements in response to the CY 2003 PART review by conducting detailed program evaluations for its program activities, and by better linking PART results and performance results to program budget requests.



A review of aging demographics shows how critical the need for cost-effective services that allow seniors to remain independent is and will continue to be in the future: In FY 2002, there were more than 4.6 million seniors, age 85 and over – and these numbers are growing faster than any other age cohort. By 2007, they are projected to total 5.6 million and 9.6 million by the year 2030. While advances in medicine and technology are enabling seniors to live longer and more active lives than ever before, those of advanced age are also at increased risk of chronic disease and disability.

Older Americans with chronic conditions are often unable to perform basic activities of daily living, and may require assistance to remain at home and avoid the need for institutional care. The May 1999 General Accounting Office report, *Adults with Severe Disabilities: Federal and State Approaches for Personal Care and Other Services*, found that "obtaining personal care on what is often a daily basis is critical for avoiding institutionalization…. Without help from family, friends, or public programs, affording such assistance may be problematic".

STRATEGIC GOAL 7

Improve the Stability and Healthy Development of Our Nation's Children and Youth

Highlighted Programs:

7a. Child Support Enforcement (ACF)

7b. Foster Care, Adoption, and other Child Welfare Programs (ACF)

7c. Head Start (ACF)

In order to promote the development and stability of our Nation's children and youth, HHS will support programs that increase the involvement and financial support of non-custodial parents; increase the percentage of children and youth living in a safe and stable environment; and, continue to support the social and cognitive development of preschool children.

Over twelve HHS programs in one OPDIV contribute to achieving this strategic goal. Three programs are highlighted in this strategic goal including ACF Child Support Enforcement, Child Welfare, and Head Start programs.

The Child Support Enforcement program assures that support is available to children by locating parents and establishing paternity and support obligations. These efforts will continue to be an integral part of the Department's effort to increase parental responsibility by promoting the involvement of non-custodial parents in the lives of their children.

The Child Welfare programs will continue to support States and localities in their efforts to keep children living in a safe, stable and permanent environment. Services offered include preventive intervention, where appropriate, so that children can remain in their homes, identifying alternative placements like foster care when necessary, and reunification services so that a child can return home. HHS will also support research and demonstrations that focus on the prevention and treatment of child abuse, neglect, and family violence.

The Head Start program ensures that children are ready to succeed upon entering school by supporting their social and cognitive development. Head Start programs provide comprehensive child development services, including educational, health, nutritional, social, and other services, to primarily low-income families. Head Start also engages parents in their child's preschool experience by helping them achieve their own educational, literacy, and employment goals; supporting parents' role in their children's learning; and emphasizing the direct involvement of parents in the administration of local Head Start programs.

PROGRAM 7A: CHILD SUPPORT ENFORCEMENT
Administration for Children and Families (ACF)

Performance Measure: *Increase the IV-D (child support) collection rate for current support.*

In accordance with HHS Strategic Goal 7, HHS is taking steps to improve the stability and healthy development of the Nation's children and youth. Child Support Enforcement (CSE) demonstrates this commitment to the Nation's children and youth in several ways. The CSE program ensures that support is available to children by locating parents, establishing paternity, and enforcing support obligations. Since the creation of the Child Support Enforcement program, child support collections within the program have grown annually. States have increased collections by using a wide variety of approaches such as income withholding, offset of income tax refunds, and reporting to credit bureaus.

In addition, new collection tools and program improvements, such as new hire reporting and increasing statewide automation, have increased collections and will continue to do so as these tools become fully implemented in all states. The Office of Child Support Enforcement is committed to achieving a higher performance level by focusing on improved enforcement techniques and ensuring maintenance of more reliable data, with particular emphasis placed on automated mechanisms for enforcement, collections, and payments to families. The Deficit Reduction Act includes a series of provisions to strengthen and improve the CSE program. These program developments improve collection of medical child support, strengthen existing collection and enforcement tools, reduce Federal expenditures, and allow States the option to provide additional support to the families who need it most.

Performance Measure: Increase the IV-D (child support) collection rate for current support.

Year	Target	Actual
2007	63%	09/2008
2006	62%	09/2007
2005	61%	09/2006
2004	60%	59%
2003	58%	58%
2002	55%	58%

Data Source: OCSE Form 157.

Data Validation: All states were required to have a comprehensive, statewide, automated Child Support Enforcement system in place by October 1, 1997. Fifty-two states and Territories were Family Support Act-certified and PRWORA-certified as of October 2005. Certification requires states to meet automation systems provisions of the specific act. Continuing implementation of these systems, in conjunction with cleanup of case data, improves the accuracy and consistency of reporting. Data reliability audits are conducted annually by OCSE. There is a substantial time lag in data availability. The OCSE Audit Division has completed the FY 2004 data reliability audits; for FY 2001 and succeeding years, the reliability standard is 95 percent.

Performance Budget Reference: ACF FY 2007 CJ, Pg.M-23

The program participated in the FY 2005 PART assessment and received a rating of Effective. OMB recommended that the program continue to build on its success in child support collection, improve medical support enforcement (provision of medical insurance for children), and encourage responsible parenthood.

CSE will continue its efforts to achieve the FY 2007 target for the current support collections measure by using all available enforcement tools. The current support collection rate performance target jumps to 63 percent in FY 2007, a one percent increase from the FY 2006 target of 62 percent. The total amount of child support distributed as current support in FY 2004 was $16.5 billion, approximately a five percent increase over FY 2003. The total amount of current support due in FY 2004 was $28 billion, which is approximately a three percent increase over FY 2003. This provides a collection rate for current support of 59 percent, up from 58 percent in FY 2003, which missed the target for FY 2004 by one percentage point. This measure is a proxy for the regular and timely payment of support. It directly indicates achievement of the performance target by comparing total dollars collected for current support in IV-D cases with total dollars owed for current support in IV-D cases.

Strategies to increase collections in recent years have resulted in the following:

- The government collected $1.5 billion in overdue child support from federal income tax refunds for tax year 2004 on behalf of more than 1.4 million families.
- A program to match a list of delinquent parents with financial institution records found over 1.9 million accounts during 2004 belonging to about 1.1 million delinquent non-custodial parents nationwide with a value in excess of $4 billion.
- A program to match a list of delinquent parents with financial institution records found over 1.9 million accounts during 2004 belonging to about 1.1 million delinquent non-custodial parents. These efforts resulted in reported collections of over $98 million. (The $98 million includes some collections from in-State matches as not all States are able to separate collections.)
- The Passport Denial program resulted in reported lump sum collections of over $13.25 million of child support payments in FY 2004.
- Using the expanded Federal Parent Locator Services, OCSE was able to provide States information on nearly 4.2 million non-custodial parents and putative fathers.

PROGRAM 7B: FOSTER CARE, ADOPTION, AND OTHER CHILD WELFARE PROGRAMS

Administration for Children and Families (ACF)

Performance Measure: *Increase the adoption rate (for children with involvement in the public child welfare system).*

The Administration for Children and Families (ACF) Child Welfare programs prevent maltreatment of children, provide in-home services for at-risk children and families, find temporary foster placements for children who must be removed from their homes, and achieve safe and stable permanent placements for children in foster care. Foster Care provides stable environments for those children who cannot remain safely in their homes and ensures children's safety and well-being while their parents attempt to resolve the difficulties that led to the out-of-home placement. When the family cannot be reunified, it provides a stable environment until the child can be placed permanently with an adoptive family, in a guardianship arrangement or some other permanent placement. Federal adoption programs work to facilitate adoptions for children with involvement in the public child welfare system by providing funds to States for adoption assistance agreements with parents who adopt children with special needs; promoting recruitment of adoptive parents; providing financial incentives to states to encourage adoptions; and working to eliminate barriers to adoption.

As part of the CY 2005 PART process, ACF replaced a prior measure of total adoptions for children with involvement in the public child welfare system with a new adoption rate, which is calculated from the annual number of adoptions divided by the number of children in foster care at the end of the prior year. The new adoption rate outcome measure better reflects the performance of the programs by taking into account the number of children in foster care. For example, while the total number of adoptions did not meet the FY 2004 goal of 53,000 adoptions for children with involvement in the public child welfare system, the adoption rate for FY 2004 was 9.8 percent, representing an increase over the FY 2003 rate of 9.4 percent.

The goal is to increase the adoption rate to 9.9 percent by FY 2007 and 10 percent by FY 2008. This target is ambitious, but realistic considering the declining number of children in foster care, the aging of the foster care population, and the decrease in the proportion of children with a placement goal of adoption.

Performance Measure: Increase the adoption rate.*

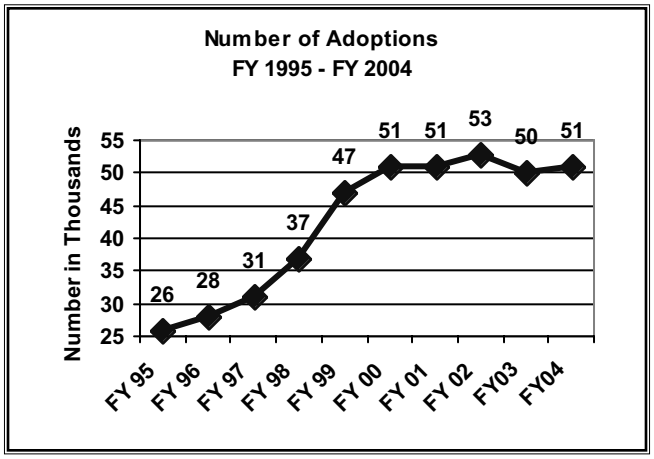
Year	Target	Result	
		Adoption	Adoption Rate
2007	9.9%	10/2008	
2006	9.85%*	10/2007	
2005	54,000	10/2006	
2004	53,000	51000	9.79%
2003	58,500	50,000	9.19%
2002	56,000	53,000	9.72%
2001	51,000	51,000	9.24%
2000	46,000	51,000	8.99%
1999	41,000	47,000	8.41%
1998	Baseline	37,000	7.16%
1997	Pre-baseline	31,000	6.11%
1996	Pre-baseline	28,000	5.80%
1995	Pre-baseline	26,000	5.71%

Data Source: Adoption and Foster Care Analysis Reporting System (AFCARS) for FY 1998 and all subsequent years; Adoption Incentive Program and the Adoption 2002 Initiative for FY 1997 and all years prior.

Data Validation: States report child welfare data to ACF through the Adoption and Foster Care Analysis Reporting System (AFCARS). All state semi-annual AFCARS data submissions undergo extensive edit-checks for internal reliability. The results of the AFCARS edit-checks for each of the six-month data submissions are automatically generated and sent back to each state, to help the state to improve data quality.

Performance Budget Reference: ACF FY 2007 CJ, Pg M-48.

* This measure was changed from the absolute number of adoptions to the adoption rate.



Although the annual number of adoptions had increased dramatically from 26,000 adoptions for children with involvement in the public child welfare system in FY 1995 to 53,000 adoptions by FY 2002, since FY 2000, the annualnumber of adoptions has leveled off. Significant proportions of the adoptions finalized from FY 1998 through FY 2000 were children who had been in the public child welfare system for a long time and who represented a backlog of cases. With improved case-practice under the reforms implemented by the Adoption and Safe Families Act (ASFA), the large backlogs of adoption cases needing to be finalized are being eliminated. At the same time, the age of children "waiting" to be adopted continues to increase, with almost half of the "waiting" children being over the age of nine. In addition, the proportion of children in foster care for whom adoption is identified as the appropriate permanency plan has also declined. These trends make adoption placement more challenging.

The program will continue to report data on the total number of adoptions along with the adoption rate through FY 2006. The information in the chart shows the annual number of adoptions of children with involvement in the public child welfare system. Preliminary data indicate that there were 51,000 adoptions in FY 2004, although this number may increase as additional adoptions for that year are reported.[1]

[1]AFCARS permits the reporting of adoptions finalized in one year to be reported in later years. The current FY 2004 number of adoptions is 51,000. Based on previous experience, it is likely, with new AFCARS adoptions submissions and resubmissions from the states, that the number of adoptions finalized in FY 2004 will increase by as much as 2,000 adoptions.

STRATEGIC GOAL 7C: HEAD START
Administration for Children and Families (ACF)

Performance Measure: *Increase the percentage of teachers with AA, BA, Advanced Degree, or a degree in a field related to early childhood education.*

Intended for preschoolers from low-income families, Head Start promotes school readiness by enhancing the social and cognitive development of children through the provision of educational, health, nutritional, social, and other services. Head Start programs emphasize cognitive, language, and socio-emotional development to enable each child to develop and function at his or her highest potential. Head Start also engages parents in their children's learning and helps parents to make progress toward their educational, literacy, and employment goals.

The Head Start Act requires that at least 50 percent of all teachers have an AA, BA, or degree in a field related to early childhood education. Head Start grantees are required to develop plans for using their allocation to increase the number of teachers with degrees. Head Start has shown a steady increase in the number of teachers with BA, AA, or advanced degrees in early childhood education and has met the requirements of the Head Start Act. For FY 2005, 69 percent of Head Start's teachers have an AA degree or higher, which exceeded the FY 2005 target of 65 percent. Of the 55,839 Head Start teachers, 18,355 have an AA degree, 17,538 have a BA degree, and 2,641 have a graduate degree. Numbers not included in the percentage are an additional number of teachers with a Child Development Associate (CDA) or state credential (no degree): 12,288. Of those teachers, 8,443 are enrolled in Early Childhood Education (ECE) degree programs. The total FY 2005 figure represents an increase of 2,061 degreed teachers over the previous year. In FY 2007, the target is to achieve 71 percent.

Performance Measure: Increase the percentage of teachers with AA, BA, Advanced Degree, or a degree in a field related to early childhood education.

Year	Target	Result
2007	71%	01/2008
2006	65%	01/2007
2005	65%	69.0%
2004	56%	64.8%
2003	50%	57.5%
2002	47%	51.0%

Data Source: Program Information Report (PIR).

Data Validation: Data collection for the PIR is automated to improve the efficiency in the collection and analysis of data. Head Start achieves a 100 percent response rate annually from 2,600 respondents. The Head Start Bureau engages in significant monitoring of Head Start grantees. ACF regional office and central office staff, along with trained reviewers, conduct more than 500 on-site reviews each year.

Performance Budget Reference: ACF FY 2007 CJ, Pg. M-36.

The Head Start program participated in the CY 2002 PART process and received a rating of Results Not Demonstrated. Based on this assessment it was recommended that the program:

- Implement and operate a National Reporting System designed to assess every 4-year-old in Head Start in the fall and spring of their preschool year. Head Start has already implemented the NRS, which assesses the school readiness of children via three cognitive measures. Assessments of children in every Head Start center were completed in Fall 2003, Spring 2004, Fall 2004, Spring 2005, and Fall 2005 through the NRS, which examined success in preparing children for school.
- Work with Congress to pass a bill that would better integrate Head Start, child care and state operated pre-school programs. Head Start reauthorization proposals, which contain elements that increase Head Start-preschool integration, are currently awaiting action in Congress.
- Develop annual performance measures that assess the progress of individual grantees in improving school readiness and better measure the impact on children. The Secretary established an Advisory Committee on Head Start Accountability and Educational Performance Measures to make recommendations about further development of the National Reporting System and other performance monitoring activities that assess progress of grantees in improving children's school readiness.

Based on progress on PART recommendations, Head Start is preparing for PART reassessment in the Spring of 2006.

STRATEGIC GOAL 8
Achieve Excellence in Management Practices

Highlighted Programs:

8a. Medicare Integrity Program (CMS)

HHS is committed to improving the efficiency and effectiveness of the Department's programs by creating an organization that has a citizen-based focus, is results oriented, and is market-driven, where practicable. Approximately three HHS programs in three OPDIVs contribute to achieving this strategic goal. The Medicare Integrity Program initiative is highlighted in this section. Program integrity efforts ensure the Medicare program pays the right amount to legitimate providers for covered, reasonable, and necessary services that are provided to eligible beneficiaries.

The President's Management Agenda identifies key elements needed for HHS to achieve its commitment to effective management. In particular, HHS is dedicated to improving management of our financial resources; using competition to obtain the best price for services acquired; improving the management of our human capital and tying human capital goals to program performance goals; using technology wisely and in a cost effective manner; and achieving budget and performance integration.

As displayed on page six in the Overview, HHS is committed to achieving excellence in management practices through implementing the President's Management Agenda. In FY 2007, HHS will continue to recruit appropriately skilled employees through the Emerging Leaders program. HHS will also use the PART assessment to inform budget decisions, program improvements, legislative proposals, and management actions.

STRATEGIC GOAL 8A: MEDICARE INTEGRITY PROGRAM
Centers for Medicare & Medicaid services (CMS)

Performance Measure: *Reduce the Percentage of Improper Payments Made Under the Medicare Fee-for-Service Program*

The Medicare Integrity Program (MIP) plays a crucial role in meeting the requirements of improving financial performance under HHS Strategic Plan Goal 8 to achieve success in management practices. CMS started measuring the percentage of improper payments made under the Medicare program in 1996 and created a goal to reduce this percentage. CMS now has five goals representing the MIP. These include reducing the contractor error rate and improving the provider compliance error rate.

The Comprehensive Error Rate Testing (CERT) program was initiated in FY 2003 and has produced a national error rate for each year since its inception. The OIG calculated the error rate for years before those included in the FY 2003 report. In 2004, CMS began reporting gross error rates in addition to the net error rates previously reported. This change was necessary in order to comply with new Improper Payments Information Act (IPIA) requirements. For the purposes of this display and the sake of consistency, we have included the gross improper payment measures for FY 2002 and FY 2003 (shown in parentheses) along with the error rates which have been more publicized. The targets for those two years were calculated for net error rates (overpayments minus underpayments as oppose to overpayments plus underpayments).

One of CMS' major goals is to pay claims properly the first time. Paying right the first time saves resources and ensures the proper expenditure of limited Medicare trust fund dollars. Beginning with the 2002 PART process, CMS worked with OMB to set ambitious annual targets for its program integrity goals for FY 2004 and beyond. The goal then was to bring the error rate down to 4.8 percent by FY 2008. In fact, in FY 2005, CMS achieved a 5.2 percent improper payment rate exceeding its target of 7.9 percent and has therefore adjusted future targets to make them more aggressive. The FY 2004 Medicare Integrity Program PART assessment completed in 2002 found that the program has a clear purpose, is managed well overall and relies on performance measures that are directly relevant to the program purpose.

Performance Measure: Reduce the Percentage of Improper Payments Made Under the Medicare Fee-for-Service Program

Year	Target	Result
2007	4.9%	11/2007
2006	5.1%	11/2006
2005	7.9%	5.2%
2004	4.8%	10.1% (recalculated baseline)
2003	5.0%	5.8%* (10.8%)
2002	5.0%	6.3% (8%)

Data Source: CMS assumed responsibility for measuring the Medicare fee-for-service error rate beginning in FY 2003 with oversight by the OIG. Error rate and improper payment rate information for years prior to the FY 2003 report was compiled by the OIG.

Data Validation: The CERT program is monitored for compliance by CMS through monthly reports from the contractors. In addition, the OIG periodically conducts reviews of CERT and its contractors.

Performance Budget Reference: CMS FY 2007 CJ, Pg 257.

* This figure was adjusted due to a higher than expected non-response rate. The actual statistically significant rate was 9.8 percent.

MIP's ability to leverage private sector entities through its contracting authority has proven to be effective. The CERT program has provided CMS with a powerful tool to identify problems in the claims process and address these problems through specific corrective action plans. Additionally, new Medicare contractor reform legislation, enacted through the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), will further enhance MIP's effectiveness.