Section II: Performance Section

FY 2006 Performance and Accountability Report

Section II: Program Performance Report

Overview

The Department of Health and Human Services (HHS) manages hundreds of programs. HHS is one of the largest Federal agencies, the Nation's largest health insurer, and the Federal Government's largest grant-making agency. The HHS mission is to protect and promote the health and well-being of all Americans while providing world-class leadership in the areas of biomedical research, public health, and social services. HHS programs impact all Americans on a daily basis, through direct services and funding, scientific advances, and educational information that allow people to choose better health care options, medicine, and even food. Through numerous grants and other financing arrangements with both public and private service providers, HHS is committed to improving overall health and human service outcomes and the economic independence of individuals and families throughout the United States.

The HHS Strategic Plan for FY 2004 – FY 2009 outlines the HHS strategic direction. The eight strategic goals in the plan guide HHS in accomplishing its mission of protecting and improving the health and well-being of the American public. These eight goals provide a focus point for HHS program investments and serve as a framework for the measures that track the Department's overall performance. The Office of the Secretary is responsible for providing overall policy guidance and direction to the Operating Divisions (OPDIVs) to help achieve the Department's strategic goals.

The strategic goals, performance goals, and program results reflect the combined commitment and effort of HHS programs, and their state, local, Federal, Tribal and non-government partners. These program partners will spend the overwhelming majority of the funds expended for HHS programs in FY 2006 to better the lives of all Americans. The HHS Strategic Plan is available at http://aspe.hhs.gov/hhsplan/.

For a comprehensive view of all HHS performance goals and program activities, including the latest performance results, see the performance plans and reports included in the budget justifications to Congress for the individual HHS OPDIVs or the FY 2008 performance budgets that will be submitted to Congress in February 2007.

Reporting Performance Results
Sound information and data are essential to fulfilling the HHS mission of enhancing the health and well being of every American. Whether providing for effective health and human services, or fostering sustained advances in the sciences or public health system, reliable information is an essential tool used in planning, measuring results, and making sound decisions. Accordingly, the Department plays an essential role in producing the necessary data for program decision making, both as a direct producer and as a partner in data collection with the States, grantees, and other governmental agencies. The HHS Data Council maintains a directory of all the major data systems supported by HHS OPDIVs, and all surveys on its website (http://aspe.hhs.gov/datacncl/index.shtml). These data systems support most of the performance measurement objectives within HHS programs, as well as various broad health and social outcome indicators.

The Performance Report presents, by strategic goal, highlights of FY 2006 performance. Each strategic goal section is introduced by an overview of the strategic goal and the selected programs that support the strategic goal. The individual program performance narratives begin with a discussion on the program's significance and benefits for achieving the performance goal; followed by an analysis of recent results including a historical trend table; and completed with an explanation on data collection, data

completeness, and data reliability. New indicators often lack data needed to establish targets. For such indicators, the first year's target may be to establish a baseline, and thus met the target for gathering the data as planned and establishing targets for the subsequent year.

Data Completeness
If available, the results for the most recent year are listed as *Actual* in the performance table for each performance measure. However, given the November 15 deadline for submission of the Performance and Accountability Report, not all data have been compiled and finalized for the entire year. When an actual result is not available for the current year, the date (month/year) for when data will be reported is cited. HHS will report the results of performance measures in future reports submitted to Congress and next year's PAR.

Data Limitations
Data that originates from external or third-party sources are not directly controlled by HHS. These data often come from annual reports or sample surveys. Several HHS programs rely on data provided by States, local grantees, and other external party sources, which require time for post-collection processing and analyzing. Some HHS data are not collected annually. For example, the Head Start program's goal "to achieve at least 80 percent of children completing the Head Start program rated by parent as being in excellent or very good health" experiences a data lag. The data for this goal are collected through the Family and Child Experiences Survey (FACES) study, an ongoing longitudinal study of program quality and impact. Because FACES has triennial cohorts, data for a comparable sample of 4-year-olds in Head Start is only available every three years. Data for the 2003 FACES cohort from the 2003-2004 program year are reported in FY 2004, FY 2005, and FY 2006. A new 2006 FACES cohort will begin in the 2006-2007 program year and report on data in FY 2007, FY 2008, and FY 2009. Additional data limitations are further discussed in the program performance narratives.

Data Reliability
HHS performance data are useful to program managers and policy makers. But because performance results in a given year are influenced by multiple factors, some of which are beyond HHS's control, and some of which are due to random chance, there may be considerable variation from year to year. A better "picture" of performance may be gained by looking at results over time to determine if there is a trend.

For a large, diverse organization like HHS that works to accomplish its mission indirectly — in partnership and by assisting others, performance measurement is challenging. The Department seeks continuous improvement in its selection of goals and in policies and procedures for collecting and reporting program performance data so that managers and other decision makers can rely on them. However, each program must consider the costs and benefits of gathering and managing such information. Changes take time to implement and reporting requirements can impose considerable burdens on staff, partners, beneficiaries and regulated entities.

Program Evaluations
The Department is committed to continuously improving the effectiveness of our services. HHS uses program evaluations to examine the performance of programs in achieving their intended objectives. Annually, the Department produces the Performance Improvement report to make available to our stakeholders one source of information--current to the previous fiscal year--that summarizes evaluation studies recently completed and others in progress. The annual report communicates the findings and recommendations of completed evaluation studies. More detailed information regarding this report can be found at http://aspe.hhs.gov/pic/perfimp/index.html.

In addition to this summary evaluation report, HHS programs continually participate in independent program evaluations. The Office of the Inspector General, the Government Accountability Office, and external parties routinely conduct program evaluations on our programs.

For the past five years, HHS has actively participated in the Program Assessment Rating Tool (PART) process, an evaluation tool used for reviewing program performance. As a result of a PART review, a program receives a rating and recommendations for program improvements. In many cases these recommendations may involve a more comprehensive program evaluation or changes in program legislation. More detailed PART information is included after the discussion of strategic goal 8 and can be found at www.ExpectMore.gov.

STRATEGIC GOAL 1:

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

Each year, HHS has the opportunity to renew its commitment to reduce health threats and promote healthy behaviors. This strategic 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.

This report highlights three programs that contribute to achieving this strategic goal 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 significant number of children in the United States are not adequately protected from vaccine-preventable diseases. Prevention remains at the center of the HHS approach to fighting HIV/AIDS. HHS is making considerable progress toward reducing the transmission of HIV from pregnant women to their children.

Through the Substance Abuse Prevention and Treatment Block Grant program, States make available alcohol and drug treatment and prevention services to every community. 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.

Highlighted Programs

- 1a: CDC National Immunization Program
- 1b: CDC HIV/AIDS Prevention
- 1c: SAMHSA Substance Abuse Prevention and Treatment Block Grant

1a National Immunization Program
Centers for Disease Control and Prevention (CDC)

Significance
Appropriate administration of safe and effective vaccines is one of the most successful and cost-effective public health tools in preventing disease, disability, and death and reducing economic costs resulting from vaccine-preventable diseases. An economic evaluation of the impact of seven vaccines [Diphtheria Tetanus acellualar Pertussis (DTaP), Tetanus diphtheria (Td), Haemophilus influenzae type b (Hib), inactivated poliovirus, measles mumps rubella (MMR), hepatitis B (Hep B), and varicella] routinely given as part of the childhood immunization schedule found that vaccines are tremendously cost effective. Routine childhood vaccination with these seven vaccines, which prevent nearly 14 million cases of disease and 33,000 deaths over the lifetime of children born in any given year, resulted in annual cost saving of $9.9 billion in direct medical costs and an additional $43.3 billion in indirect costs.

Performance Measure	Fiscal Year 2006		
	Target	Actual	Result
Achieve or sustain immunization coverage of at least 90% in children 19- to 35-months of age for: 4 doses DTaP vaccine, 3 doses Hib vaccine, 1 dose MMR vaccine, 3 doses hepatitis B vaccine, 3 doses polio vaccine, 1 dose varicella vaccine, 4 doses pneumococcal conjugate vaccine	90% coverage	8/2007	Deferred
Data Source: National Immunization Survey			

Result Analysis
FY 2006 data will be available in August 2007 after collection, analysis, and verification processes are completed. The target of 90 percent coverage was met in FY 2005 for most of the vaccines, except for varicella and DTaP containing vaccine.

In 2005, the coverage rate for four doses of DTaP did not yet achieve the 90 percent goal. The coverage rate for the fourth dose has steadily increased since the change to a four dose schedule, as recommended by the Advisory Committee for Immunization Practices (ACIP) in 1991. This goal will be difficult to achieve because it requires that the fourth dose be given to the child between 15 and 18 months of age, an age that does not coincide with regular well-baby visits. Coverage rates are 96 percent for the first three DTaP doses. Although the first three doses are considered to be most critical, CDC and the ACIP recommend that the fourth and fifth doses are important for full vaccination. The fifth dose is recommended for children between four and six years of age. Varying state requirements for the four-dose vaccine schedule may have also led to a slower increase in coverage.

In 2005, the coverage rate for varicella vaccine did not yet achieve the 90 percent goal. Varicella is the most recently introduced vaccine that has a measurable target. Varicella rates are rising with coverage at only 43 percent in 1998 reaching 88 percent in 2005. CDC is close to meeting the 90 percent varicella vaccines 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. To meet the 90 percent coverage goal for DTaP and varicella CDC is doing the following: identifying and improving coverage in "pockets of need;" using reminder and recall systems to improve immunization levels in children and adults; and developing software tools to assess immunization coverage in health care settings and increasing immunization coverage rates.

In 2001, the ACIP added pneumococcal conjugate vaccine (PCV) to the Recommended Childhood Immunization Schedule. Accountability for PCV performance targets begins in FY 2006. PCV is already impacting the incidence of invasive pneumococcal disease. According to a recently published study, the incidence of invasive pneumococcal disease was 77 percent lower among white children less than two

years of age and 89 percent lower among black children less than two years of age in 2002, compared to 1998-1999 averages. This vaccine is projected to prevent more than one million episodes of childhood illness and approximately 116 deaths among children annually. Please refer to the ACIP's recommended vaccine schedule at http://www.cdc.gov/nip/recs/child-schedule-color-print.pdf for more information.

Trends	Fiscal Year Actual				
Performance Measure	**2002**	**2003**	**2004**	**2005**	**2006**
Achieve or sustain immunization coverage of at least 90% in children 19- to 35-months of age for:					
4 doses DTaP vaccine,	DTaP 95%;	DTaP 96%;	DTaP 86%;	DTaP 86%;	8/2007
3 doses Hib vaccine,	Hib 93%;	Hib 94%;	Hib 94%;	Hib 94%;	
1 dose MMR vaccine,	MMR 91%;	MMR 93%;	MMR 93%;	MMR 92%;	
3 doses hepatitis B vaccine,	Hepatitis B 90%;	Hepatitis B 92%;	Hepatitis B 92%;	Hepatitis B 93%;	
3 doses polio vaccine,	Polio 90%;	Polio 92%;	Polio 92%;	Polio 92%;	
1 dose varicella vaccine,	Varicella 81%	Varicella 85%	Varicella 88%	Varicella 88%	
4 doses PCV	PCV: N/A	PCV: N/A	PCV: N/A	PCV: N/A	

Data Collection
The National Immunization Survey (NIS) uses a nationally representative sample and provides estimates of vaccination coverage rates that are weighted to represent the entire population nationally, and by region, state, and selected large metropolitan areas. The NIS, a telephone-based survey, is administered by random-digit-dialing to find households with children aged 19 to 35 months. Parents or guardians are asked about the vaccines–with dates–that appear on the child's "shot card" kept in the home, and demographic and socioeconomic information is also collected. At the end of the interview with parents or guardians, survey administrators request permission to contact the child's vaccination providers. Providers are contacted by mail to provide a record of all immunizations given to the child.

Completeness
The sample is nationally representative and estimates of vaccination coverage are weighted to represent the entire population nationally, and by regions, state and selected metropolitan statistical areas. To assure data are complete and accurate, the results of the telephone survey are verified through contact with the vaccination provider. In 2005, 88.0 percent of Immunization History Questionnaires sent to providers were returned. During 1996-2004, this rate ranged from 76.0 percent (in 1996) to 95.3 percent (in 1998), with a median of 87.3 percent (in 2004).

Reliability
Examples of quality control procedures include 100 percent verification of all entered data with a sub-sample of records independently entered. Biannual data files are reviewed for consistency and completeness by CDC's National Immunization Program and National Center for Health Statistics (NCHS). Random monitoring by supervisors of interviewers' questionnaire administration styles and data entry accuracy occurs daily. Annual methodology reports are available to the public.

1b HIV/AIDS Prevention
Centers for Disease Control and Prevention (CDC)

Significance
HIV remains a deadly infection for which there is no cure. Over 500,000 Americans have died of AIDS and an estimated 1.039 million to 1.185 million Americans are currently infected with the virus. CDC has been involved in the fight against HIV and AIDS from the earliest days of the epidemic and remains a leader in HIV/AIDS prevention and control. While HIV incidence has decreased substantially, from an estimated 150,000 new infections per year in the late 1980s, new infections remain unacceptably high at an estimated 40,000 per year.

CDC's core set of HIV prevention activities includes surveillance, research, intervention, capacity building, and evaluation. Surveillance provides demographic, laboratory, clinical, and behavioral data that are used to identify populations at greatest risk for HIV infection. These data also help CDC estimate the size and scope of the epidemic. The number of HIV infection cases among persons under 25 years of age diagnosed each year is 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 addition, these data enable CDC to look at yearly trends in a meaningful way.

Performance Measure	Fiscal Year 2006		
	Target	Actual	Result
Reduce the number of HIV infection cases diagnosed each year among people under 25 years of age.	Overall: 2,420 reported cases in 30 areas	11/2007	Deferred
Decrease the number of perinatally acquired AIDS cases from the 1998 base of 235 cases.	<100 cases	11/2007	Deferred
Data Source: Adult and Pediatric Confidential HIV/AIDS Case Reports			

Result Analysis
Data are from a national surveillance system that collects demographic, clinical, and behavioral information on all AIDS cases diagnosed in the U.S., as well as HIV cases diagnosed in States that report HIV data to CDC. In FY 2003, performance targets were set for FY 2004 when only 25 States had stable, confidential name-based HIV reporting. After the FY 2004 targets were set, five additional areas were added for a total of 30 areas. As a result of the addition of five areas, the FY 2006 target was changed to reflect the new total of 30 areas. Areas can include States, local health departments or U.S. territories, so "state" and "area" are not interchangeable terms. In FY 2004, there were 3,465 cases reported in 30 areas with confidential name-based reporting. Data for FY 2005 and FY 2006 will be available in November 2006 and 2007, respectively, due to data collection, analysis, and verification processes.

A dramatic reduction in perinatal (mother-to-child) HIV transmission cases has been noted in the United States, a result of the widespread implementation of the Public Health Service recommendations made in 1994 and 1995. Recommendations included routinely counseling and voluntarily testing pregnant women for HIV, and offering zidovudine 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 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. Surveillance data reported through December 2003 show sharply declining trends in perinatal AIDS cases. Data for FY 2004 continues to show low levels of perinatally acquired AIDS cases, from 109 in 2002 to 48 in 2004. This decline was strongly associated with increasing zidovudine use in pregnant women who were aware of their HIV status. More recently, improved treatment also has likely delayed onset of AIDS for HIV-infected

children. However, declines may be affected by treatment failures and missed opportunities to prevent transmission. Data for FY 2005 and FY 2006 will be available in November 2006 and 2007, respectively.

Trends	Fiscal Year Actual*				
Performance Measure	**2002**	**2003**	**2004**	**2005**	**2006**
Reduce the number of HIV infection cases diagnosed each year among people under 25 years of age.	2,154 in 25 states; 3,028 in 30 areas	2,286 in 25 states; 3,134 in 30 areas	2,606 in 25 states; 3,465 in 30 areas	11/2006	11/2007
Decrease the number of perinatally acquired AIDS cases from the 1998 base of 235 cases.	109	69	48	11/2006	11/2007

*As data continue to be refined, surveillance results found in source documentation will vary slightly from those previously reported.

Data Collection
HIV surveillance data is collected from state and local health departments using the "Adult and Pediatric Confidential HIV/AIDS Case Reports." HIV data collection systems vary between areas (e.g., name-based, coded identifier, name-to-code data collection systems). On July 5, 2005, CDC sent a letter to all States and territories recommending that all States and territories adopt confidential name-based surveillance systems to report HIV infections. Currently, 43 state and local health departments use confidential name-based reporting of HIV infection while 13 other state, territorial, and local health departments used code-based or name-to-code methods. 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 trends in incidence, HIV and AIDS surveillance data are analyzed by the date of diagnosis and are mathematically adjusted in more recent periods to adjust for reporting delays and incomplete information on some cases. CDC requires a minimum of 12 months after the end of a calendar year to provide accurate estimates of trends for that year.

Completeness
Program staff review data submitted by state and local health departments for completeness and accuracy. By relying only on data from areas using confidential, name-based reporting, the data can be checked for multiple entries for the same individual. Duplicate entries are not included in surveillance reports. Statistical analysis is performed by program staff other than those responsible for the surveillance data.

Reliability
Surveillance data undergoes accuracy checks at the program level. Analysis is conducted by different program staff. The "HIV/AIDS Surveillance Supplemental Report" is produced annually by CDC. Prior to publication, the report and surveillance data are reviewed at the division level, the National Center level, and the CDC/Office of Director level.

1c Substance Abuse Prevention and Treatment Block Grant
Substance Abuse and Mental Health Services Administration (SAMHSA)

Significance
The Substance Abuse Prevention and Treatment Block Grant is the cornerstone of States' substance abuse programs and is an integral part of the President's drug treatment initiative. States are heavily dependent upon block grant funding for urgently needed substance abuse services.

The impact of substance use disorders is seen in damage to the Nation's children, the transmission of HIV/AIDS and other communicable diseases, criminal involvement, premature and preventable deaths, and economic and social consequences estimated to have cost the Nation more than $328 billion per year. The block grant supports and expands substance abuse prevention and treatment, while providing maximum flexibility to the States.

Performance Measure	Fiscal Year 2006		
	Target	Actual	Result
Increase the number of clients served.	1,983,490	10/2008	Deferred
Data Source: SAMHSA, Office of Applied Studies. Drug Abuse Services Information System Treatment Episode Data Set.			

Result Analysis
Data collected by the Drug Abuse Services Information System Treatment Episode Data Set (DASIS-TEDS) showed 1,875,026 substance abuse treatment admissions in FY 2004, 2.6 percent below the target of 1,925,345. SAMHSA/CSAT is working with the States to encourage the adoption of a wide variety of evidence-based practices to increase outreach and access to substance abuse services. Through the State Outcomes Measurement and Management System contracts, SAMHSA is working with the States to ensure the accuracy of client counts reported through the Treatment Episode Data Set.
FY 2004 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.

This measure is one of SAMHSA's National Outcome Measures (NOMS), which, when fully implemented, 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. As States begin to report unduplicated counts, DASIS-TEDS might show that that the number of admissions has gone down, since re-admissions of the same individual in the reporting period would be counted as a single client served. Future targets may be adjusted to reflect this change.

Trends	Fiscal Year Actual				
Performance Goal	2002	2003	2004	2005	2006
Increase the number of clients served	1,882,584	1,840,275	1,875,026	10/2007	10/2008

Data Collection
DASIS-TEDS is a compilation of data on substance abuse treatment events (admissions and discharges), that are routinely collected by States in monitoring their individual substance abuse treatment systems. It includes, primarily, information on clients admitted to programs that receive public funds. States extract data from their administrative data systems and submit them to SAMHSA over the course of a two-year period for each annual file. When the files are closed, they represent a 12-month period of admissions for substance abuse treatment.

States are responsible for reviewing the quality of their data. Each State is responsible for ensuring that each record in the data submission contains the required key fields, that all fields in the record contain valid codes, and that no duplicate records are submitted. States are also responsible for cross-checking

data items for consistency across data fields. The internal control program consists of a rigorous quality control examination of the data as they are received from States. They are examined to detect values that fall out of the expected range based on the State's historical trend. If such outlier values are detected the State is contacted to validate the value or correct the error. Detailed instructions governing data collection, review, and cleaning are available at: http://wwwdasis.samhsa.gov/dasis2/manuals/teds_adm_manual.pdf.

The highlighted measure used is the number of clients served by the Substance Abuse Prevention and Treatment Block Grant. As a proxy measure, the Substance Abuse and Mental Health Services Administration (SAMHSA) utilizes the number of admissions to substance abuse treatment reported to the Treatment Episode Data Set (DASIS-TEDS). DASIS-TEDS does not include all admissions to substance abuse treatment. It includes facilities that are licensed or certified by the State substance abuse agency to provide substance abuse treatment (or are administratively tracked for other reasons). In general, facilities reporting DASIS-TEDS data are those that receive State alcohol and/or drug agency funds (including Federal Block Grant funds) for the provision of alcohol and/or drug treatment services.

Completeness
The two year period for data collection is to allow adequate time for States to collect data from providers, extract the DASIS-TEDS variables from their systems, crosswalk them to the standard DASIS-TEDS format, and submit them to SAMHSA. Limitations to DASIS-TEDS are related to the scope of the data collection system (e.g., the fact that DASIS-TEDS collects data on admissions rather than individuals), and to the difficulties of aggregating data from highly diverse state data collection systems. A more detailed discussion of data limitations is available at: http://www.nationaloutcomemeasures.samhsa.gov/new_reserve/teds.asp

Reliability
The proxy data reported represent treatment admissions data. These data are used as a proxy for persons served because many States currently are unable to employ a unique client identifier, which is necessary in order to track unduplicated numbers of clients served. States are working toward providing unduplicated counts of the number of clients served.

STRATEGIC GOAL 2:

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

HHS has a number of initiatives and programs directed at protecting Americans from bioterrorist attacks and other public health challenges. The events of Hurricane Katrina, 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.

This report highlights three programs that contribute to achieving this strategic goal including the Food and Drug Administration's (FDA) Field Foods Program, Health Resources and Services Administration's (HRSA) Hospital Preparedness Program, and CDC's Terrorism Preparedness and Emergency Response Program.

FDA works to supply responsive regulatory review of new biodefense medical countermeasures and plays a major role by inspecting high risk domestic food manufacturers and enhancing 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 goals described in this section represent HHS' progress towards building the necessary infrastructure to respond to bioterrorist and other public health challenges.

Highlighted Programs

- 2a: FDA Field Foods Program
- 2b: HRSA Bioterrorism Hospital Preparedness program
- 2c: CDC Terrorism Preparedness and Emergency Response program

2a Field Foods Program
Food and Drug Administration

Significance
FDA's Prior Notice Center was established in response to regulations promulgated in conjunction with the Public Health Security and Bioterrorism Preparedness Act of 2002. This Act requires notification to the FDA [specifically the Prior Notice Center] that an article of food, including animal feed or pet food, is being imported or offered for import into the United States in advance of the arrival of the article of food at the U.S. border. The Prior Notice Center's mission is to identify imported food products that may be intentionally contaminated with biological, chemical, or radiological agents, or which may pose significant health risks to the American public, and to prevent them from entering into the United States. The Prior Notice Center targets food and animal feed commodities that have been identified as high-risk based on either threat assessments that have been conducted or the receipt of specific intelligence indicating the items may cause death or serious injury due to terrorism or other food related emergencies.

Performance Measure	Fiscal Year 2006		
	Target	Actual	Result
Perform prior notice import security reviews on food and animal feed line entries considered to be at risk for bioterrorism and/or present the potential of a significant health risk.	45,000	89,034	Met
Data Source: Field Data Systems			

Result Analysis
In FY 2006, FDA achieved this goal by collaborating with the Department of Homeland Security's Customs and Border Protection to direct field personnel to conduct 89,034 intensive security reviews of Prior Notice Submissions in order to identify products that may be contaminated before they enter the food supply. This exceeded the FY 2006 target by 44,034.

It should be noted that the number of import security reviews performed by the Prior Notice Center is contingent on the total number of Prior Notice Submissions that match targeted criteria based on intelligence, known risk factors, and other information regarding individuals and companies of interest involved in the shipping process. FDA is not able to know in advance how many of the prior notices submitted will need to have security reviews since the candidates are selected on the basis of risk factors and not in relation to the volume of submissions.

Trends	Fiscal Year Actual				
Performance Measure	2002	2003	2004	2005	2006
Perform prior notice import security reviews on food and animal feed line entries considered to be at risk for bioterrorism and/or present the potential of a significant health risk.	N/A	N/A	33,111	86,187	89,034

Data Collection
All prior notice data regarding incoming shipments is submitted electronically via the Automated Broker Interface of Department of Homeland Security's Customs and Border Protection's Automated Commercial System and/or FDA's web-based Prior Notice System Interface. It is not until the prior notice contains the minimal data element requirements and has passed the internal validation edits that a prior notice confirmation number is issued electronically to the submitter. The data then is screened against the risk-based criteria and flagged for intensive manual review.

The manually reviewed prior notice data is scrutinized for accuracy and verified in historic and contemporary shipping and law enforcement databases to uncover derogatory information and potential discrepancies. The prior notice data and any additional shipment data obtained from the databases are sorted through an automated targeting system that assimilates the data and further associates it with sensitive information contained in law enforcement databases maintained by Department of Homeland Security's Customs and Border Protection's and other agencies.

Based on the comprehensive outcome of this research, a decision is made whether to allow the shipment to proceed to FDA general admissibility status, to refuse the shipment until all data is submitted correctly and adequately, or to classify the shipment as a potential bioterrorism or significant public health threat following consultation with CBP and direct FDA field investigators and/or the 9,500 CBP field agents available to examine the shipment prior to entering the country.

Completeness
The completeness of the prior notice security review can be assessed at each level of the review process described in the Data Collection section. The first step helps ensure that the prior notice minimally contains data for all the required fields. This step is entirely electronic, and is ascertained for effectiveness routinely by the contractors.

Reliability
Once the completeness of the data has been verified, the next step of the process subjects the data to a series of validation edits. This step is also entirely electronic, and the contractors routinely determine its effectiveness. Throughout the process the data is vetted in conjunction with CBP using internal, external and classified sources. Reviewers also manually complete a research sheet for each shipment that they review.

Adjustments to the editing and rejection process can be tested on the reporting data for effectiveness prior to implementation. Likewise, the separation of high-risk products from the entire pool of prior notice submissions involves establishing electronic criteria that target and mark elements of the prior notice data that coincide with intelligence and prevailing risk assessments.

2b National Bioterrorism Hospital Preparedness Program
Health Resources and Services Administration (HRSA)

Significance
The goal of the Bioterrorism Hospital Preparedness program, which is part of the President's Homeland Security Initiative, is to ready hospitals and supporting health care entities to deliver coordinated and effective care to victims of terrorism and other public health emergencies. The program requires that States in cooperation with hospitals and other health care entities develop plans to address surge capacity in response to potential terrorist and other threats. Surge capacity is the hospital and supporting health care entity's ability to evaluate and care for a markedly increased volume of patients—one that exceeds normal operating capacity. This requirement is based on the concept that improved outcomes can be achieved when critical components of preparedness are formalized in a plan and organized into a system of care. While a plan alone is insufficient to being prepared, the plan is foundational. Without a plan a State's hospitals and health care system will not be prepared. The performance measure indicates the extent to which program awardees have met the requirement to develop plans to address surge capacity.

Performance Measure	Fiscal Year 2006		
	Target	Actual	Result
Percent of awardees that have developed plans to address surge capacity	100%	100%	Met
Data Source: Grantees' progress reports			

Result Analysis
The number of awardees that have developed plans for a potential incident involving at least 500 casualties per million in each jurisdiction contributes to an adequate level of preparedness to respond to a mass casualty event. By FY 2005, 100 percent of awardees had developed such plans, and, as awardees were the same, 100 percent had surge capacity plans in FY 2006, meeting the target. Plans for surge capacity 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. Plans focus on *capacity* of the delivery system. Now that all awardees have plans in place, the program is focusing on *capability*, i.e., the ability to operate based on the plan as indicated by training, exercises, evaluation, and corrective actions.

Trends	Fiscal Year Actual				
Performance Measure	2002	2003	2004	2005	2006
Percent of awardees that have developed plans to address surge capacity	N/A	59%	89%	100%	100%

Data Collection
Information for this measure was obtained through review of awardees' FY 2004 end-of-the-year progress reports, and awardees' FY 2005 mid-year progress reports.

Completeness
All data submitted by awardees are self-reported. The completeness of this data is checked through progress report reviews and site visits conducted by project officers.

Reliability
All data submitted by awardees are self-reported. The reliability of this data is checked through progress report reviews and site visits conducted by project officers.

2c Terrorism Preparedness and Emergency Response
Centers for Disease Control and Prevention (CDC)

Significance
It is important to exercise preparedness plans to identify gaps, prepare and implement corrective action plans, and evaluate activities. The Division of State and Local Readiness (DSLR) provides funding and written guidance via the Public Health Emergency Preparedness Cooperative Agreement to 62 States, territories, and local public health departments.

The public health system's ability to respond may be validated by either mock events or actual events. Mock events may include one or more activities (e.g., case studies, scenarios, tabletop/desktop exercises, partial-system/whole-system exercises, small-/large-scale multi-jurisdictional exercises, etc.). Mock events allow CDC to quickly identify and address gaps (e.g., preparedness plans, staffing, equipment, training) that prevent timely, efficient and effective responses.

Performance Measure	Fiscal Year 2006		
	Target	Actual	Result
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.	100%	12/2006	Deferred
Data Source: Grantee Progress Reports			

Result Analysis

The FY 2005 target of 25 percent was met for this measure. FY 2006 data are expected by December 2006. Grantees submit semi-annual progress reports on May 1 and November 30 of each year. The May reports are included with grantee applications, budgets and work plans; the November reports are included with Financial Status Reports and cover activities for the fiscal year. All reports are submitted via the Division of State and Local Readiness' (DSLR) electronic management information system, DSLR MIS. Following the analysis of the November reports, the FY 2006 result will be updated. Because the performance measure was established during DSLR's FY 2005 PART review, FY 2005 was the first required reporting year.

Trends	Fiscal Year Actual				
Performance Measure	2002	2003	2004	2005	2006
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.	N/A	N/A	N/A	94% of state public health agencies have developed plans for at least one priority agent	12/2006

Data Collection
Via DSLR MIS, each grantee submits an annual application, work plan and two semi-annual grantee progress reports. The Public Health Emergency Preparedness Cooperative Agreement provides the format for applications. The DSLR MIS simultaneously notifies the CDC Project Officer when the application is ready for review and prevents further changes by the grantee until the Project Officer provides recommended changes. A detailed technical review is conducted by CDC Project Officers and Subject Matter Experts. DSLR's Outcome, Monitoring, and Evaluation Branch monitor MIS, review data entered by grantees, and collaborate with Project Officers to address identified issues. The Director also meets weekly with Division Directors for briefings on status, priority issues and action plans.

Completeness
DSLR MIS provides a standard format for data reporting among grantees. Semi-annual progress reports are self-reports by grantees, which may affect the quality of data reported. Through the above monitoring process, and ongoing communication with grantees, DSLR's Outcome, Monitoring, and Evaluation Branch (or more appropriate subject) helps ensure the highest possible level of accuracy of information at the time of release.

Reliability
DSLR's Outcome, Monitoring, and Evaluation Branch continually works to validate received data and strengthen the link between technical assistance, training, tools and written guidance provided by CDC and the enhancement and maintenance of state and local public health capacity. The review and monitoring processes facilitate reliability by emphasizing consistent standards, multi-level reviews, ongoing communication and information-sharing.

STRATEGIC GOAL 3:

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

The Department is working to expand health care to all and remains committed to its many efforts aimed at increasing the percentage of the Nation's children and adults who have access to care and expanding consumer choices. The Department will also continue to promote increased access to health care 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.

Seven programs are highlighted in this strategic goal including Health Resources and Services Administration's (HRSA) Health Centers Program, HRSA's Ryan White program, Indian Health Service (IHS) National Diabetes Program, SAMHSA Children's Mental Health Services, Centers for Medicare and Medicaid (CMS) Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP).

HRSA's Health Centers program makes available regular access to high quality, family oriented, and comprehensive primary and preventive health care regardless of patients' ability to pay. IHS' National Diabetes program works with communities to prevent and treat diabetes in American Indian/ Alaska Native people. CMS' Medicaid 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. In coordination with Medicaid, SCHIP has stimulated enormous change in the availability of health care coverage for children. For over four decades, CMS Medicare has helped pay medical bills for millions of aged and disabled Americans and has afforded them with comprehensive health benefits.

Highlighted Programs

- 3a: HRSA Health Centers Program
- 3b: HRSA Ryan White Program
- 3c: IHS National Diabetes Program
- 3d: SAMHSA Children's Mental Health Services
- 3e: CMS Medicaid and the State Children's Health Insurance Program
- 3f: CMS Medicare
- 3g: CMS Medicare Quality Improvement Organizations

3a Health Centers Program
Health Resources and Services Administration (HRSA)

Significance
Health centers are a major component of America's health care safety net for the Nation's low-income, underserved, and vulnerable populations. This program, which is over 40 years old, is part of a Presidential initiative to increase health care access for those Americans most in need. This initiative, begun in FY 2002, has the goal of significantly impacting 1,200 communities through the creation of new or expanded access points. Health centers provide regular access to high quality, family-oriented, and comprehensive primary and preventive health care, regardless of patients' ability to pay, while also reducing other barriers to care. The ultimate goal of the Health Centers program is to contribute to improvements in the health status of underserved and vulnerable populations and to the elimination of health disparities. The three performance measures reported here are key indicators of expanded access to care and increased availability of services for the Nation's most vulnerable populations.

Performance Measure	Fiscal Year 2006		
	Target	Actual	Result
Increase the number of uninsured and underserved persons served by health centers.	14.62 M*	08/2007	Deferred
Continue to assure access to preventive and primary care for racial/ethnic minorities.	64% 9.35 M	08/2007	Deferred
Increase the infrastructure of the health center program to support an increase in utilization via: total new or expanded sites.	121	122	Met
Data Source: Persons served: The HRSA/Bureau of Primary Health Care Uniform Data System. Sites: The Bureau of Health Care Delivery and Assistance Network and the HRSA Electronic Handbooks.			

*Revised performance target published in FY 2007 Congressional Justification.

Result Analysis
Health centers served 14.1 million persons in FY 2005, exceeding the target by 100,000 persons. This represents growth of over one million persons from the previous year and growth has increased by nearly four million persons since the beginning of the President's Initiative.

The number of racial/ethnic minority individuals served by health centers increased from 8.3 million in FY 2004 to nearly 9 million in FY 2005, continuing a steady growth consistent with the overall growth in program clients. The proportion of racial/ethnic minority individuals has remained steady at about 64 percent of total clients, only one percentage point below the FY 2005 target of 65 percent. Some of the new health center sites established under the President's Initiative are in underserved rural areas that do not have large numbers of racial/ethnic minorities. The substantial and rapid increases in the total number of clients served and expansions in areas with relatively small proportions of racial/ethnic minorities impact the program's ability to maintain and increase the proportion of minority clients served. Therefore, maintaining a racial/ethnic representation of 64 percent of total clients is an important achievement.

FY 2006 data on patients served will be available in August 2007. These data are reported annually on a calendar year basis. Data are collected each February for the previous year and aggregate reports are finalized in August after an extensive data cleaning and editing process occurs.

To provide additional required facilities, personnel, and services in communities of greatest need, the Health Centers program has funded 899 new or significantly expanded sites between FY 2002 and FY 2006, exceeding the target each year. In FY 2006, 122 new or expanded sites were funded.

Trends	Fiscal Year Actual				
Performance Measure	**2002**	**2003**	**2004**	**2005**	**2006**
Increase the number of uninsured and underserved persons served by health centers	11.32 M	12.4 M	13.1 M	14.1 M	08/2007
Continue to assure access to preventive and primary care for racial/ethnic minorities	64% 7.24 M	64% 7.92 M	63.5% 8.34 M	63.6% 8.99 M	08/2007
Increase the infrastructure of the health center program to support an increase in utilization via: total new or expanded sites	302	188	129	158	122

Data Collection
HRSA-funded health centers report program statistics annually through the Uniform Data System (UDS). The UDS contains a core set of data that is used for program monitoring and performance management. Grantees report data on total patients served, the racial/ethnic composition of their patient population, as well as other demographic, administrative, financial, and utilization information. The data collected and compiled in the UDS are available at the grantee, state, regional, and national levels.
The Bureau of Health Care Delivery and Assistance Network (BHCDANET) is an agency mainframe system with business rules to generate unique grantee and site identifiers. BHCDANET maintains data on all sites that are included in the Health Centers grantees' approved "scope of project" and is updated regularly by Health Centers program staff as new site and scope information is received from grantees. HRSA Electronic Handbooks, a HRSA-wide web based grants management portal, also compiles and maintains Notice of Grant Awards, which are issued when new and expanded site funding is awarded to health centers.

Completeness
All HRSA-funded health centers are required to report to UDS as a condition of their grant award. Technical assistance is provided to health centers to assist them on matters related to the completeness, reliability, and accuracy of data reported to the UDS. The UDS contractor and trained editors edit and clean submitted UDS data using over 1,000 edit checks, both logical (e.g., consistency across data tables and totals) and specific (e.g., significant increases or decreases in certain values). These include checks for missing data and outliers and checks against history and norms. The data are not finalized until all editing and reviewing procedures are completed.

BHCDANET contains hard code editing checks built into the operating platform of the mainframe system. In addition, Health Centers program staff update the data regularly, ensuring its completeness.

Reliability
The reliability of the data is assured in the same way as completeness.

3b Ryan White CARE Act program
Health Resources and Services Administration (HRSA)

Significance
HRSA's Ryan White CARE Act program serves as the focal point for the Federal response to the primary care and social support needs for poor and vulnerable persons living with HIV/AIDS. The program targets funding toward the development of an effective service delivery system by partnering with States, heavily-impacted metropolitan areas, community-based providers, and academic institutions. Specific HIV/AIDS health services include medical care, access to life-saving medications for the treatment of HIV/AIDS, dental care, outpatient mental health services, outpatient substance abuse treatment, and home health care.

An important component of the care provided is informing persons of their serostatus (HIV status) following testing. This is essential for the program's efforts to get infected persons into appropriate HIV-related medical care and for efforts to contain the spread of the disease. Much has changed in the epidemiology and medical management of HIV/AIDS since the Ryan White CARE Act was enacted in 1990. The Centers for Disease Control and Prevention estimates that 1.039 million to 1.185 million people in the United States are living with HIV/AIDS, of whom an estimated 24 to 27 percent are unaware of their serostatus. When combined with the number of people who know their serostatus but who receive care intermittently at best, it is clear that hundreds of thousands of people living with HIV/AIDS in the United States are not receiving care in keeping with current treatment guidelines. While it used to be that those diagnosed with the disease had little hope, patients today are living longer and healthier lives due to the benefits of early treatment. The program aims to increase annually the number of persons who learn of their serostatus through Ryan White CARE Act service providers.

Performance Measure	Fiscal Year 2006		
	Target	Actual	Result
Increase by 2 percent annually the number of persons who learn their serostatus from Ryan White CARE Act programs	2% over FY 2005	02/2008	Deferred
Data Source: Ryan White CARE Act Data Report			

Result Analysis
In FY 2004, the CARE Act provided 553,569 persons confirmation of their serostatus. This represents an increase of 23 percent (102,641 persons) over the previous year and exceeded the FY 2004 target by 20 percent. The FY 2005 and 2006 data will be submitted by grantees and service providers by mid-March 2006 and 2007, respectively. The 2005 and 2006 data submissions are followed by various internal and external data quality checks, and the actual results are expected in February 2007 and 2008, respectively.

Trends	Fiscal Year Actual				
Performance Measure	2002	2003	2004	2005	2006
Increase by 2 percent annually the number of persons who learn their serostatus from Ryan White CARE Act programs	N/A	450,928	553,569	02/2007	02/2008

Data Collection
The Ryan White CARE Act Data Report (CADR) is completed by all Ryan White CARE Act funded grantees and service providers. The specific CADR item for the performance measure reported here asks grantees to: "Indicate the number of individuals who, after being tested for HIV antibodies, returned for HIV post-test counseling from an individual qualified to provide such counseling, during the reporting period, regardless of their test results. This includes every individual tested for HIV, whether the test result was positive, negative, or indeterminate." All CADR data are submitted electronically on an annual basis through a single HRSA-mandated reporting portal known as the HRSA Electronic Handbooks.

Completeness
All CARE Act grantees and their service providers are required to report annual CADR data as a condition of their grant award. Data completeness, accuracy, consistency, and reliability are ensured by two types of data quality checks. First the CADR data as entered by grantees are checked through a series of automatic edit checks that are built into this electronic data reporting and management system. Entered data cannot be accepted and submitted until these internal checks are completed and any problems resolved. In addition, data quality checks are performed by project officers and data specialists who monitor and review the CADR submissions with the goal of providing technical assistance to grantees, when needed, to improve data quality.

Reliability
Reliability is checked in the same way as completeness.

3c National Diabetes Program
Indian Health Service (IHS)

Significance
The IHS National Diabetes Program, now known as the Division of Diabetes Treatment and Prevention, was authorized by Congress in 1997 in response to alarming trends documenting a disproportionately high rate of type 2 diabetes in American Indian and Alaska Native (AI/AN) communities. It came in the wake of increasing public concern about the human and economic cost of diabetes in the United States, and the growing prevalence among the AI/AN population. The Division of Diabetes Treatment and Prevention strives to bring Tribes and Urban Indian health programs together to share information and work towards a common purpose of improving diabetes care and outcomes. Quality diabetes care centers on blood glucose control, blood pressure control, and maintenance of normal blood cholesterol levels. Keeping these parameters within normal limits in a person with diabetes reduces microvascular and macrovascular complications. Please refer to the following website www.ihs.gov/MedicalPrograms/Diabetes for more details.

Glycemic control is one of the sentinel measures for diabetes care, and refers to how well the blood sugar levels are controlled in a person with diabetes. The sugar level is measured with a blood test called the Hemoglobin A1c, and results are categorized into the following levels: "Ideal" (<7 percent); "Good" (7.0-7.9 percent); "Fair" (8.0-9.9 percent); "Poor" (10-11.9 percent); and "Very Poor" (>12 percent). These levels are based on national diabetes care standards. Increasing the number of patients with diabetes within the ideal level lowers health care costs and reduces mortality rates associated with diabetes. Clinical studies show that lower Hemoglobin A1c levels are associated with lower heart-attack rates, lower rates of eye, kidney, and nerve disease, and fewer amputations among people with diabetes. The prevention or delay of such risk factors in people with diabetes provides value to society by improving the overall health status of the AI/AN population.

Performance Measure	Fiscal Year 2006		
	Target*	Actual	Result
Increase the proportion of patients with diagnosed diabetes with ideal glycemic control (A1c<7.0)	36/32%**	11/2006/31%	Deferred/Not Met
Data Source: Diabetic registries; yearly IHS Diabetes Care and Outcome Audit; and Clinical Reporting System extraction of data from local Resource Patient Management System databases.			

*Revised target published in FY 2007 Congressional Justification.
**First figure in Target, Actual and Results columns is Diabetes Audit data; second is Clinical Reporting System data.

Result Analysis
IHS measures glycemic control both by the Annual Diabetes Care and Outcome Audit and by the Clinical Reporting System (CRS). The FY 2006 goal for ideal glycemic control, as measured by the Annual Diabetes Care and Outcome Audit, is to maintain the 2005 rate of 36 percent, this data will be available in November 2006. The FY 2006 goal for glycemic control as measured by CRS is to increase the proportion of AI/AN patients demonstrating ideal glycemic control to 32 percent. Although IHS did not meet the glycemic control indicator based on the CRS data, it did achieve a rate of 31% percent which was a one percentage point improvement over the FY 2005 level. Meeting this target requires costly drug treatment and monitoring as well as patient compliance. Because this rate reflects patient health status rather than the provision of a specific procedure or screening, it is more costly and difficult to effect improvement within a short time frame. However, over a longer period of time, the agency has sustained improvement, increasing the proportion of patients in ideal control by six percentage points since 2002.

Trends	Fiscal Year Actual*				
Performance Measure	2002	2003	2004	2005	2006
Increase the proportion of patients	30%/25%	31%/28%	34%/27%	36%/30%	11/2006/31%

with diagnosed diabetes with ideal glycemic control (A1c<7.0)					

*First figure shown is Diabetes Audit data; second is Clinical Reporting System data.

Data Collection
In collecting Diabetes Audit data, on-site reviewers use a systematic random sampling technique to obtain a patient sample of sufficient size to provide statistically valid results. Abstracted data from chart reviews is entered locally into a database software program specifically tailored for entering and analyzing Audit data. Regional diabetes coordinators and professional clinical staff members perform the manual reviews, following instructions that use a standard Audit form and uniform set of definitions. The local data files are collected regionally and forwarded for review by the Area coordinator and the DDTP epidemiologist to resolve data errors. The data is then sent to a biostatistician at DDTP, where further error checking routines are performed prior to aggregation and weighting of the data to produce the regional and national summary reports. Following the initial error check and review, the data for each facility are released locally for use in their quality improvement efforts.

Clinical Reporting System (CRS) software passively extracts data from patient records in the IHS health information system (RPMS) at the individual clinic level. CRS is updated at least annually to reflect changes in clinical guidelines for existing measures as well as adding new measures to reflect new health care priorities. Software versions are tested first on developmental servers on large data bases and then are beta tested at facilities, before submission to IHS Software Quality Assurance, which conducts a thorough review prior to national release.

Completeness
Participation in the Diabetes Care and Outcomes Audit is voluntary, although it is strongly encouraged for all Indian health system sites. Participation is a requirement for all SDPI grant recipients that provide clinical care. The vast majority of IHS direct and Tribally administered clinics that provide diabetes care do participate, including multiple sites that have elected to use non-RPMS clinical computer systems. All Indian hospitals participate.

After local sites submit their CRS data, Area coordinators use CRS to create Area level reports, which are forwarded to the national data support team for a second review and final aggregation. These national aggregations are thoroughly reviewed for quality and accuracy before final submission. Specific instructions for running quarterly reports are available for both local facilities and the Area Office.

Reliability
The Diabetes Audit measures are comparable to the measures used for national health outcome indicators, such as the indicators implemented in the National Committee for Quality Assurance's Health Plan Employer Data and Information Set and the Centers for Disease Control and Prevention's Healthy People 2010. The IHS has implemented a number of processes, including system wide training, to increase the accuracy and amount of audit data reported.

Electronic collection, using CRS, ensures that performance data is comparable across all facilities and is based on a review of 100 percent of all patient records rather than a sample. Facility reports are submitted on a quarterly and annual basis to the GPRA coordinator for their Area, who is responsible for quality reviews of the data before forwarding reports for national aggregation. Because the measure logic and reporting criteria are hard coded in the CRS software, these checks are primarily limited to assuring all communities assigned to a site are included in the report and to identifying measure results that are anomalous, which may indicate data entry or technical issues at the local level. Comprehensive information about CRS software and logic is at www.ihs.gov/cio/crs/ .

3d Comprehensive Community Mental Health Services Program for Children and Their Families (Children's Mental Health Services)
Substance Abuse and Mental Health Services Administration (SAMHSA)

Significance
The Comprehensive Community Mental Health Services Program for Children and Their Families (Children's Mental Health Services) provides grants to States, communities, territories, Indian tribes, and tribal organizations to improve and expand their systems of care to meet the needs of children with serious emotional disturbances and their families. From 1993-2004, Children's Mental Health Services has funded 96 grants in 48 States and two territories, and has provided services to approximately 67,341 children across the United States.

The highlighted performance measure is the percentage of participants with no law enforcement contacts at six months after entering services. This measure reflects positive behavioral outcomes for program participants. Performance on this and other outcome measures can be affected by the mix of grantees in any given year and the particular characteristics of the individuals served.

Performance Measure	Fiscal Year 2006		
	Target	Actual	Result
Improve children's outcomes and system outcomes: Increase percentage of participants with no law enforcement contacts at six months.*	68%	12/2006	Deferred
Data Source: The Delinquency Survey			

*"Of participants" has been added for clarity and is not the exact wording used in the FY 2007 Congressional Justification.

Result Analysis
Data for this measure will be available in December 2006. The most recent year of data (FY 2005) exceeded the established target for that year (53 percent), with 68 percent of children with no law enforcement contacts at 6 month follow-up. Performance on this measure has steadily improved over the last several years.

Trends	Fiscal Year Actual				
Performance Measure	2002	2003	2004	2005	2006
Improve children's outcomes and system outcomes: Increase percentage of participants with no law enforcement contacts at six months*	46.5%	50.5%	67.6%	68.3%	12/2006

*"Of participants" has been added for clarity and is not the exact wording used in the FY 2007 Congressional Justification.

Data Collection
The Delinquency Survey, administered to youth 11 years of age and older and caregivers of children up to age 22, gathers information about contacts with law enforcement and delinquent behaviors. Questions are administered in an interview format directly to youth. Data are collected through interviews at baseline and at 6 months after baseline. Responses are entered into a computer-assisted interview program. The data entry program includes quality control checks to enhance the accuracy and completeness of data entered.

The program has established a consistent data collection protocol that is applied across all grantee sites. Extensive materials and training are provided on the protocol are provided. The program documents and monitors data collection procedures at all program grantee sites through a web-based data repository and monitoring system. Data cleaning and quality assessment take place first at each funded community,

and again through the automated system. Data issue reports detailing data errors and inconsistencies are prepared quarterly; local staff then make corrections and resubmit their data to the web-based system at which point data are again reviewed for errors.

Completeness
As described under Data Collection above, data completeness and quality checks are built into the computer assisted data entry submission process. Additional data quality reports are provided quarterly. Interviewer training materials address how to make sure complete data are obtained at the time of the interview. Extensive retention and tracking procedures are implemented at each system-of-care community, including mailings and telephone calls, prompt updating of locator information, and prompt follow-up on returned mail or disconnected telephone numbers. The computerized tracking system prompts staff when specific individuals need to be contacted for follow-up.

The standardized procedures and on-going technical assistance provided to grantees assure high rates of completeness. Across 28 grant communities funded in 2002-2003, staff were able to contact an average of 81 percent of program participants for 6-month follow-up. Of these communities, 8 achieved follow-up data collection rates exceeding 91 percent.

Reliability
SAMHSA staff monitor the status and quality data collection through reports from the automated system. In addition, data staff produce a monthly data collection progress report which is detailed at the site level and semi-annual reports of interview completion rates. Technical assistance is provided to address any data collection problems.

3e Medicaid and State Children's Health Insurance Program (SCHIP)
Centers for Medicare & Medicaid Services (CMS)

Significance
The State Children's Health Insurance Program (SCHIP) was created through the Balanced Budget Act of 1997 to address the fact that nearly 11 million American children (one in seven) were uninsured and therefore at increased risk for preventable health problems. Title XXI of the Social Security Act gave States the option to expand their Medicaid program, establish a separate SCHIP, or use a combination of both. CMS' goal is to increase the number of children (up to age 19 for SCHIP; age 21 for Medicaid) enrolled in regular Medicaid or SCHIP.

Performance Measure	Fiscal Year 2006		
	Target	Actual	Result
Decrease the number of uninsured children by working with States to enroll children in SCHIP and Medicaid	Increase the number of children who are enrolled in regular Medicaid or SCHIP by 3 percent, or approximately 1,000,000 over the previous year.	03/2007	Deferred
Data Source: Statistical Enrollment Data System			

Results Analysis
In 1997, the year SCHIP was enacted, there were 21,000,000 children enrolled in Medicaid and none in SCHIP. Since the SCHIP enrollment goal was initiated in FY 2000, CMS has met the proposed enrollment target each year. For FY 2005, CMS had a target to increase enrollment by three percent or 1,000,000 over the previous year. CMS met its goal and reported a yearly increase of 1,100,000 or 3.1 percent. While final FY 2006 enrollment data for the separate child health programs will be available in October 2006, the final enrollment data for Medicaid expansion and regular Medicaid programs will not be available for CMS review and compilation until the end of January 2007. Final FY 2006 data reports will be available March 2007.

Trends	Fiscal Year Actual				
Performance Measure	2002	2003	2004	2005	2006
Decrease the number of uninsured children by working with States to enroll children in SCHIP and Medicaid	+3,100,000	+2,200,000	+2,300,000	+1,100,000 or 3.1%	03/2007

Data Collection
SCHIP regulations require States to report annual/quarterly information no later than 30 days after the end of each fiscal year/quarter. The annual and quarterly report for statistical data is submitted for children enrolled in a separate child health program, a Medicaid expansion program and a regular Medicaid program. Data is submitted through the Statistical Enrollment Data System (SEDS) on the internet. For each program the States report aggregate data on the unduplicated counts of children ever enrolled in the year and each quarter, and for the quarterly reports the aggregate data also includes the number of new enrollees, the number of disenrollees, the number of member months. In addition, the actual number of children currently enrolled on the last day of the quarter is reported. Aggregate data for gender, race, and ethnicity is also required by SCHIP regulations and States report this information on a CMS form in SEDS. Data is analyzed weekly by staff members to ensure that all States have reported necessary information and to ensure the consistency of data. Specifically, staff members review previously submitted state data and compare to current submissions to identify any inconsistencies between time periods. Where inconsistencies occur, staff work with States to identify reasons for inconsistency or provide technical assistance to correct any identified inaccuracies.

Completeness
The SCHIP Statistical Enrollment Data System (SEDS) allows data analysts to view the status of the completeness of each state's reporting for any past Federal fiscal year (FFY) quarter. The SCHIP data analyst monitors the progress the States make to track and report States that have past due data (States must report within 30 days after the end of a FFY quarter). The check for completeness informs CMS whether any state has omitted any required forms. The quality/accuracy check is more subjective, the data analyst is able to identify anomalies in the most recently submitted data compared to past data, and also is able to check for reasonableness, i.e., is the point in time number smaller than the ever enrolled number, is the average number of member months in a quarter less than or equal to three, etc. The primary data limitation is that data is state reported and the interpretation of the SEDS data collection instructions may not be exactly the same across the 50 States and District of Columbia that are reporting. The data is collected and aggregated by each state and reported via the internet into the SEDS. States do not send paper copies of their reports to audit the system for data entry accuracy, so the reliability of the data is dependent on each state's data collection, aggregation, and input into SEDS.

Reliability
As described above, CMS ensures the reliability of SEDS data by analyzing it on a weekly basis. CMS works to ensure that all States have reported necessary information and the consistency of data. Specifically, staff members review previously submitted state data and compare to current submissions to identify any inconsistencies between time periods. Where inconsistencies occur, staff work with States to identify reasons for inconsistency or provide technical assistance to correct any identified inaccuracies.

3e Medicaid and State Children's Health Insurance Program (SCHIP)
Centers for Medicare & Medicaid Services (CMS)

Significance
In FY 2002, CMS began working with States to jointly explore a strategy for State and Federal use of performance measures. The Performance Measurement Partnership Project (PMPP) is a course of action developed to use reliable and valid performance measures to quantify and stimulate measurable improvement in the delivery of quality health care. The PMPP is CMS' first effort to develop performance measures based on consensus and voluntary State participation. Sharing best State practices and opportunities for improved performance reporting is intended to assist States in enhancing their overall State Quality Medicaid Improvement Strategies, which will result in improved services and health outcomes for Medicaid recipients. CMS will use the results from the PMPP as the building blocks for the development of a national framework for Medicaid quality. This framework will be developed in collaboration with States and key stakeholders. Encouraging the use of national recognized performance measurement is an integral part of the agency's performance goal and the CMS Medicaid Quality Strategy.

Performance Measure	Fiscal Year 2006		
	Target	Actual	Result
Improve Health Care Quality Across Medicaid and SCHIP	Medicaid: Collect, on a voluntary basis, 2003 performance measurement data from a minimum of 13 States, and continue to provide technical assistance to States to improve performance measurement calculation and reporting.	Collected data from 13 States and provided technical assistance.	Met.
	SCHIP: Improve reporting by States on core performance measures in order to have at least 25% of States reporting four core performance measures in FY 2005 Annual Report.	At least 25% of States reported four core performance measures in FY 2005 report.	Met.
Data Source: SCHIP annual reports, State Annual Report Template System, Medical Statistical Information System, and Health Plan Employer Data and Information Set.			

Results Analysis
Medicaid
After several years of data collection evaluation efforts, it is evident that the States continue to have great variation in system capabilities, quality improvement expertise, and performance measurement knowledge. In July 2005, CMS rolled-out the Quality Improvement Road-Map with the vision for "the right care for every person every time." The road-map outlines system improvement strategies for improving care. The initiative provided a timely opportunity to redefine and refocus the Medicaid Quality Goal. The Performance Measurement Partnership Project will complete measurement of State performance measurement reporting in September 2006 to broaden analysis beyond reporting and identify improvement in overall quality in Medicaid services.

The contractor completed the 2006 final report titled "Thirteen State Medicaid Core Performance Measure Reporting Summary: Highlighting Model Practices." The report also reflects that additional analyses were performed on trended data through 2004 to support quality improvement goals and implementation of the Medicaid and SCHIP quality strategy.

SCHIP

States have shown dramatic improvement in reporting performance measures since the collection of the FY 2003 baseline data. SCHIP's target for this goal reflect the next steps – the collection, analysis, and dissemination of States' quality improvement strategies toward establishing and enhancing quality improvement in SCHIP nationwide.

Trends	Fiscal Year Actual				
Performance Measure	2002	2003	2004	2005	2006
Improve Health Care Quality Across Medicaid	N/A	Reported on meeting results; identify strategy for gauging improvement; implemented recommendations.	Updated timeline to implement recommendations; Identified strategy to improve health delivery/quality; implement recommendations.	Refined strategy; collected 2002 data from 10 states; provide technical assistance.	Collected data from 13 states and provided technical assistance.
Improve Health Care Quality Across SCHIP	N/A	Worked with States on the PMPP: Reported on results of the meeting with States and identified a timeline for implementing recommendations; Identified a strategy for improving health care delivery and/or quality, and specified measures for gauging improvement; Initiated action steps for implementing recommendations; and Began to implement core SCHIP performance measures.	Refined data submission; produced standard measures; collected 2003 baseline data.	Collected core performance measures; used new automated template to evaluate data; provided technical assistance to States.	At least 25 percent of States reported four core performance measures in FY 2005 report.

Data Collection

Data was collected for one year for this report to assess the use of performance measures identified through the Performance Measurement Partnership Program. The data was collected by CMS' contractor. To identify the ten States included in the report, the contractor performed an extensive Web search for publicly available quality/performance data. The contractor began with the States that were interviewed earlier in 2005 under a separate effort. They then expanded the search to include all 50 States to ensure that best practices were being identified. After identification of the States, the contractor extracted the publicly reported data from the websites and created their own data base for use in the report. Each State included in the report had the opportunity to review the data for accuracy. Recommendations for changes to the report from the States were incorporated as appropriate. A site visit

was recently completed for one of the States listed in the report and supporting documents were obtained to validate the report contents.

Beginning in FY 2003, CMS began collecting SCHIP performance measures through the SCHIP annual reports. In addition, CMS created an automated web-based system – State Annual Report Template System (SARTS), which allows States to input and submit their annual reports to CMS via the internet. This system also allows CMS to better analyze data submitted by States, including monitoring the progress States are making toward meeting their individual goals related to the SCHIP core performance measures. States began reporting in SARTS, on a voluntary basis, for the SCHIP FY 2003 Annual Reports. In 2003-2004, two States were piloted for assessing ability to report performance measurements via administrative data in Medical Statistical Information System (MSIS). States were supportive of the effort, but continued to implement performance measures via other mechanisms, such as Health Plan Employer Data and Information Set (HEDIS) reporting. In 2005, performance measures publicly reported from ten States were evaluated in conjunction with State quality improvement initiatives.

Completeness
During this screening phase, the contractor created a database summarizing materials collected from all States. The contractor combined this information with data from the aforementioned interviews and statistics from CMS regarding State enrollment and managed care penetration. Variables to identify best practices included: performance measure characteristics, years collected and reported, and whether States have implemented performance improvement programs. The contractor selected States that had the greatest depth and longevity of quality measurement, focusing on Health Plan Employer Data Information Set (HEDIS) / PMPP measures. The contractor also looked for States that had implemented interventions and completed re-measurement and/or had Fee-For-Service (FFS) / Primary Care Case Management (PCCM) information available. Sixteen candidate States were identified, of which ten were comprehensively reviewed. There are limitations in the data which are clearly stated in the report. The primary limitation is that the report relies upon secondary data collected by the States which have different methods of validating the data. Four States used a standard validation process while the other processes varied.

Reliability
Management ensured reliability of data by first participating in the evaluation design phase with the contractor and subsequently by directly reviewing a sample of the primary data sources (e.g. reviewing the web based information from which the report was derived). Additionally, each State included in the report had the opportunity to review the data for accuracy. Recommendations for changes to the report from the States were incorporated as appropriate. A site visit was recently completed with one of the States listed in the report and supporting documents were obtained to validate the report contents.

3f Medicare
Centers for Medicare & Medicaid Services (CMS)

Significance
The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 provides all Medicare beneficiaries access to prescription drug coverage can reduce their spending on prescription drugs. CMS has completed the implementation of management processes and IT infrastructure necessary to manage the Part D program. The successful implementation of systems addressing claims, oversight, and contractor management has enabled CMS to implement the Part D program on time and has established the foundation for a strong program management structure that will reliably deliver prescription drugs to Medicare beneficiaries at a reduced price.

Performance Measure	Fiscal Year 2006		
	Target	Actual	Result
Implement the New Medicare Prescription Drug Benefit 1a. Percentage of people with Medicare that know that people with Medicare will be offered/are offered prescription drug coverage starting in 2006	*1. a. 49.4%	67%	Met
b. Percentage of beneficiaries that know that out-of-pocket costs will vary by the Medicare prescription drug plan	b. 52.5%	69%	Met
c. Percentage of beneficiaries that know that all Medicare prescription drug plans will not cover the same list of prescription drugs	c. 28.4%	50%	Met
2. Implement a Part D Claims Data System, oversight system, and contractor management system.	2. Implement a Part D Claims Data System, oversight system, and contractor management system.	2. Implemented a Claims Data System; Improved oversight reduced call center wait times; and implemented Contractor Management System.	Met
Data Source: National Medicare Education Program Assessment Survey			

*Revised target was published in the FY 2007 Congressional Justification.

Result Analysis
The National Medicare Education Program (NMEP) Assessment Survey was completed in September 2006. The new drug benefit was implemented in 2006 and consumers were first surveyed in 2005 to measure public knowledge of the new program. FY 2006 survey targets were developed using FY 2005 results as a baseline. The operational targets have been completed as follows:

Claims Data System: CMS' Drug Data Processing System has been in operation since the launch of the program. Plans were required to submit Prescription Drug Event (PDE) data to CMS by the end of the first quarter and thereafter, PDE records must be submitted to CMS electronically at least once a month. Program Oversight: On June 26, 2006, CMS issued a press release showing the improvements in plan call center wait times from April 6, 2006 to May 31, 2006. The positive trending of this performance metric was a direct result of CMS' oversight of this issue. On April 14, 2006, CMS published the 2007 Part D

Reporting Requirements, and on April 25, 2006, published the Prescription Drug Benefit Manual on Fraud, Waste and Abuse.
Contractor Management Systems: CMS has implemented a contractor management strategy that assigned an "Account Manager" to each program sponsor. These staff completed the review of plan applications to enter the program. The application is CMS' first review of a plan's ability to administer the benefit.

Trends	Fiscal Year Actual				
Performance Measure	2002	2003	2004	2005	2006
Implement the new Medicare Prescription Drug Benefit					
1a. Percentage of people with Medicare that know that people with Medicare will be offered/are offered prescription drug coverage starting in 2006	N/A	N/A	N/A	a. 47%	67%
b. Percentage of beneficiaries that know that out-of-pocket costs will vary by the Medicare prescription drug plan	N/A	N/A	N/A	b. 50%	69%
c. Percentage of beneficiaries that know that all Medicare prescription drug plans will not cover the same list of prescription drugs	N/A	N/A	N/A	c. 27%	50%
2. Implement a Part D Claims Data System, oversight system, and contractor management system.	N/A	N/A	N/A	N/A	Implemented a Claims Data System; Improved oversight reduced call center wait times; and implemented Contractor Management System

Data Collection
The data source is the National Medicare Education Program Assessment Survey (NMEP), which is a nationally representative telephone survey of approximately 2,000 beneficiaries. The NMEP is intended to increase beneficiary access to, awareness of, understanding about, and use of the information to make appropriate health plan and health care delivery choices.

Completeness
The questions used in the NMEP Assessment Survey have been extensively tested with Medicare beneficiaries and the survey has been tested for reliability and validity.

Reliability
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 device.

3f Medicare
Centers for Medicare & Medicaid Services (CMS)

Significance
In response to the need to standardize the measurement of and monitor beneficiaries' experience and satisfaction with the care they receive through Medicare, CMS developed a series of data collection activities under the Consumer Assessment Healthcare Providers and Systems (CAHPS) formerly called Consumer Assessment of Health Plans Survey. CMS fielded these surveys annually to representative samples of beneficiaries enrolled in each Medicare managed care (later called Medicare Advantage, MA) plan as well as to those enrolled in the original Medicare fee-for-service plan (MFFS).

Passage of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) required modifications in the Medicare CAHPS Surveys to include measurement of experience and satisfaction with the care and services provided through the new Medicare Prescription Drug Plans (PDP) as well as the MA and MFFS health plans.

Performance Measure	Fiscal Year 2006		
	Target	Actual	Result
Improve satisfaction of Medicare beneficiaries with the health care services they receive	*Develop MMA measures to include in the Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey	Survey field tested	Met
Data Source: The Medicare Consumer Assessment of Healthcare Providers and Systems			

*Revised target was published in the FY 2007 Congressional Justification.

Results Analysis
Through FY 2005, measures related to access to care and specialist physicians were collected for beneficiaries in Medicare Advantage (MA) plans. Similar measures were collected for enrollees in the Medicare fee-for-service (MFFS) plan through FY 2004, but due to competing funds and in light of the future changes to the Medicare CAHPS, the MFFS survey was not fielded in FY 2005. Although we are unable to determine MFFS performance for FY 2005, FY 2004 results indicate strong performance for the fee-for-service measures, with access to care at 92.0 percent and access to a specialist at 86.9 percent. As a result of the MMA, the focus of this goal now shifts to MMA-related measures. Results from the FY 2005 MA measures show that while we did not reach our target for access to care, we maintained our already high level of performance. We exceeded our target for access to specialists. Data from FY 2006 for the MMA measures will be available in September 2007.

Planning for the new Medicare CAHPS Surveys began in FY 2005 and continued through FY 2006. CMS continued to work with the CAHPS Consortium through the Agency for Healthcare Research and Quality and developed a field test version of the 2006 Medicare CAHPS survey that was implemented in four states in the summer and fall of 2006. The field test results will be used to finalize the survey instruments that will then be implemented nationally in early 2007 and ask about enrollees' experiences with the Medicare health and prescription drug plans they had in 2006. This developmental performance goal will generate MMA measures that will be used to create new baselines and targets for subsequent years.

Trends	Fiscal Year Actual				
Performance Measure	**2002**	**2003**	**2004**	**2005**	**2006***
Improve satisfaction of Medicare beneficiaries with the health care services they receive. Medicare Advantage: Access to Care Specialist	Monitor annual data toward 5-year target	Monitor annual data toward 5-year target	Monitor annual data toward 5-year target	MA Access to care: 90% - MA Specialist: 93%	
Medicare fee-for-service Access to Care Specialist	Monitor annual data toward 5-year target	Monitor annual data toward 5-year target	Monitor annual data toward 5-year target	MFFS Access to care/ Access to specialist: Not measured. :	
Develop MMA measures to include in the Medicare Consumer Assessment of Healthcare Providers and Systems survey	N/A	N/A	N/A	N/A	MMA: Goal met

*As a result of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the focus of this goal for FY 2006 shifted to MMA-related measures.

Data Collection
The Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS), which is a set of annual surveys of beneficiaries enrolled in all Medicare managed care plans and in the original Medicare fee-for-service plan.

Completeness
CMS fields these surveys annually to representative samples of beneficiaries enrolled in each MA plan as well as those enrolled in the MFFS plan, and provides comparable sets of specific performance measures collected in CAHPS to our partners and stakeholders.

Reliability
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 MA-MFFS comparability weights are employed to adjust collected data for differential probabilities of sample selection, under-coverage, and item response.

3g Medicare Quality Improvement Organizations
Centers for Medicare & Medicaid Services (CMS)

Significance
For all persons age 65 or older, the Advisory Committee on Immunization Practices and other leading authorities recommend lifetime vaccination against pneumococcal disease and annual vaccination against influenza. Through collaboration among the CMS, the Centers for Disease Control and Prevention and the National Coalition for Adult Immunization, efforts are ongoing to improve adult immunization rates in the Medicare population.

In recent years, there have been influenza vaccine shortages and distribution delays, which have impacted the delivery of immunizations. Traditionally, pneumococcal immunizations are given by health care providers along with the influenza immunization, so it is possible that disruptions of influenza vaccine supply also impact pneumococcal vaccination rates.

Based on recent challenges concerning influenza vaccine supply and distribution, a decision was made to change the focus of this performance goal from the general Medicare population to nursing home residents beginning in FY 2006 because of the possibility of achieving a greater impact in the long-term care setting.

Performance Measure	Fiscal Year 2006		
	Target	Actual	Result
Protect the health of Medicare beneficiaries age 65 years and older by increasing the percentage of those who receive an annual vaccination for influenza and a lifetime vaccination for pneumococcal	*Influenza vaccination for nursing home subpopulation: 74% National pneumococcal vaccination: 69%	12/2007 12/2007	Deferred Deferred
Data Source: The Medicare Current Beneficiary Survey			

*Revised target was published in FY 2007 Congressional Justification.

Results Analysis
According to the most recent data (FY 2004), we met our National flu target and fell short of our pneumococcal target. Traditionally, pneumococcal immunizations are given by health care providers along with the influenza immunization. According to the American Medical Association, over 70 percent of pneumococcal vaccine sales in 2002 occurred in the four-month period of August through November. It is possible that disruptions of influenza vaccine supply may have impacted the pneumococcal vaccination rates also. In addition, recent studies published in the May 1, 2003 edition of the New England Journal of Medicine and the July 2003 edition of the Journal of Infectious Diseases question the effectiveness of the pneumococcal vaccine. Such reports may dissuade some health care professionals from offering pneumococcal vaccine for their older patients.

Based on recent challenges concerning influenza vaccine supply and distribution, we are focusing on nursing homes where we may have greater impact. CMS issued a final rule requiring nursing homes to provide residents with the opportunity to be immunized against influenza and pneumococcal disease as a condition of participation in the Medicare and Medicaid programs. CMS' influenza target for FY 2006 reflects this change.

Trends	Fiscal Year Actual*				
Performance Measure	**2002**	**2003**	**2004**	**2005**	**2006**
Protect the health of Medicare beneficiaries age 65 years and older by increasing the percentage of those who receive an annual vaccination for influenza and a lifetime vaccination for pneumococcal	Influenza: 69% Pneumococcal: 64.6%	Influenza: 70.4% Pneumococcal: 66.4%	Influenza: 72.8% Pneumococcal: 67.4%	12/2006 12/2006	12/2007 12/2007

*FY 2002-FY 2005 Influenza rates represent the general population. FY 2006 Influenza rates specifically represent nursing home population.

Data Collection
Currently, through the Medicare Current Beneficiary Survey (MCBS), annual estimates of immunization coverage among facility-dwelling persons with Medicare are available. CMS will continue to use MCBS data for the pneumococcal target as well as for the nursing home influenza target for FY 2006.

Completeness
MCBS is an ongoing survey of a representative national sample of the Medicare population, includes beneficiaries who reside in long-term care facilities.

Reliability
The MCBS uses Computer Assisted Personal Interview technology to perform data edits, e.g., range and integrity checks, and logical checks during the interview. After the interview, consistency of responses is further examined and interviewer comments are reviewed.

STRATEGIC GOAL 4:
Enhance the Capacity and Productivity of the Nation's Health Science Research Enterprise

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

HHS is committed to advancing the understanding of the environmental factors that contribute to human disease. In order to accomplish this objective, HHS will continue to support basic, clinical, and applied biomedical and behavioral research with stringent peer review for scientific quality of research proposals. HHS will also develop and implement processes for setting research priorities that ensure that research is responsive to public health needs, scientific opportunities, and advances in technology. HHS places a high priority on improving the coordination, communication, and application of health research results.

Three programs from the National Institutes of Health (NIH) are highlighted in this strategic goal, including Culturally Appropriate Stroke Prevention Programs for Minority Communities, Evidence-based Treatment Approaches for Drug Abuse in Community Settings, and Knowledge Base on Chemical Effects in Biological Systems (CEBS).

HHS commitment to enhancing the capacity and productivity of the Nation's health science research enterprise is demonstrated in many ways. Stroke is the third leading cause of mortality in the United States and the leading cause of adult disability, but the burden of stroke is greater among racial/ethnic minority groups by virtue of its higher incidence and mortality in these populations. NIH is conducting stroke prevention research projects to include community-based interventions, epidemiology, and/or outcome measures, to ultimately lead to the identification of effective stroke prevention and intervention strategies for a variety of community settings. One important tool to treat substance abuse is behavioral intervention, which has been shown to be effective in improving drug abuse and drug addiction outcomes. NIH is working to more rapidly bring research-based treatments to communities by adapting three treatment approaches for testing in community-based settings. The development of CEBS shows the great strides being achieved in HHS. 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 other toxicants.

Highlighted Programs

- 4a: NIH Culturally Appropriate Stroke Prevention Programs for Minority Communities
- 4b: NIH Treatment for Drug Abuse in Community Settings
- 4c: NIH Knowledge Base on Chemical Effects in Biological Systems

Significance
Stroke is the third leading cause of mortality in the United States and the leading cause of adult disability, but the burden of stroke is greater among racial/ethnic minority groups by virtue of its higher incidence and mortality in these populations. For example, African Americans have almost twice the risk of first-ever strokes compared to whites, and have higher death rates. Stroke is the fourth leading cause of death among Hispanics, and this population is particularly susceptible to hemorrhagic (or bleeding) strokes. For American Indians/Alaska Natives, the relative risk is almost 2 times higher at ages 35-44, 1.3 times higher at ages 45-54 and 1.5 times higher at ages 55-64. In fact, many minority populations have higher death rates from bleeding strokes than do whites. Both African Americans and Hispanic Americans also have a high prevalence for many comorbid health conditions that raise the risk of stroke, including high blood pressure, overweight, and diabetes. Eliminating health disparities, including stroke, is one of the Healthy People 2010 stated goals, the disease prevention agenda for the Nation.

Racial/ethnic variations in stroke-related risk factors and utilization of health care are not fully understood. Prevention programs are a preferred strategy for reducing or eliminating racial/ethnic disparities in stroke. By collecting much needed stroke-related epidemiological data in racial/ethnic minority communities and conducting stroke prevention research projects to include community-based interventions, epidemiology, and/or outcome measures, this performance goal will ultimately lead to the identification of effective stroke prevention and intervention strategies for a variety of community settings.

The success of this program will benefit society by eliminating or reducing the racial disparity between minority groups and whites in potential life-years lost. Benefits are also expected in reduced health care expenditures and lost earnings.

Performance Measure	Fiscal Year 2006		
	Target	Actual	Result
By 2010, identify culturally appropriate, effective stroke prevention programs for nationwide implementation in minority communities.	Establish the infrastructure for a pilot Alaska Native Stroke registry that will facilitate identifying risk factors and strategies to improve stroke prevention and quality of stroke care provided to Alaska Natives.	Established Alaskan Native Stroke Registry, began enrolling patients	Met
Data Source: Grant number U01NS048069, "Alaska Native Stroke Registry"			

Result Analysis
The program's FY 2006 annual target was met when NIH awarded funding to the Alaska Native Medical Center for an Alaskan Native Stroke Registry in September 2005. This registry builds on the Medical Center's extensive experience with chronic disease registries and will provide critical information on the disparity in stroke mortality. A Scientific Advisory Committee for the registry project has been formed and has met five times. This committee has developed a list of data elements pertinent to Alaskan Natives that live in a rural setting, including culturally unique risk factors. A web-based data collection tool has also been created. The registry began entering patient data on October 1, 2005. As of June 2006, 71 patients had been enrolled in the registry.

Trends	Fiscal Year Actual				
Performance Measure	2002	2003	2004	2005	2006
By 2010, identify culturally appropriate, effective stroke prevention programs for nationwide implementation in minority communities.	N/A	Established seventeen Nursing Partnership Centers to reduce health disparities, including stroke, which link research-experienced nursing schools with minority-serving nursing schools across the nation.	Established acute stroke care center serving a minority community in Washington, DC metropolitan area.	Established research infrastructure and advisory committees, and hired director for Stroke Prevention and Intervention Research Program.	Established Alaskan Native Stroke Registry, began enrolling patients

Data Collection
A Scientific Advisory Committee (SAC) composed of the Principal Investigator, the Nurse Coordinator, and local experts assisting the project will meet at least quarterly to discuss the project and make sure that performance targets are met. Minutes from these meetings will be forwarded to the NIH staff and the Program Advisory Committee (PAC). The PAC is made up of national experts in stroke, epidemiological research, and NIH staff. The PAC will meet yearly to evaluate the Principal Investigator and the SAC, help set new appropriate performance targets, and assess the direction of the overall project. A yearly PAC report will be created for the Principal Investigator and Institutional Officials suggesting ways to improve the performance of the project and move the science forward. Based on the recommendations by the PAC, the Principal Investigator will create new performance targets in the form of an implementation plan that will be placed the notice of grant award for the subsequent fiscal year.

Completeness
Both active and passive case surveillance (e.g., review of hospital logs, review of hospital discharge diagnosis codes, community surveys) will be used to identify patients within the Alaska Health Care System. Patient data will be entered into a web-based registry for purposes of case management and quality improvement. Once the data are complete, patient identifiers are removed and the data is moved to a separate, pooled data set used for epidemiologic and research purposes.

Reliability
NIH program staff evaluates the performance of this program based on the quarterly SAC minutes, yearly PAC meetings, PAC recommendations, and yearly non-competing progress reviews.

4b Treatment for Drug Abuse in Community Settings
National Institutes of Health (NIH)

Significance
The total costs of drug abuse and addiction (including tobacco, alcohol, and illicit drugs) to our Nation are almost $524 billion, including health care expenditures, lost earnings, and costs associated with crime and accidents. Without alcohol, the cost is approximately $338 billion. Although research has demonstrated that drug abuse treatment can be effective in reducing drug use and addiction, few research-based interventions have been developed and tested widely within the health care field.

One important tool to treat substance abuse is behavioral intervention, which has been shown to be effective in improving drug abuse and drug addiction outcomes. This performance goal is an effort to more rapidly bring research-based treatments to communities by adapting three treatment approaches for testing in community-based settings. It also targets specialized populations that are often underrepresented in drug abuse research and underserved in treatment programs: minorities, adolescents, families, and women diagnosed with Post-Traumatic Stress Disorder. The results of these trials will generate much needed information on how to implement effective treatments in a variety of community settings and allow clinicians to improve the delivery of scientifically-based treatments to drug abuse patients.

The success of this program will improve the overall health of the Nation, lessen the negative impact drugs can inflict on individuals, families, and communities, and reduce the total costs of illicit drug abuse and addiction to society. As the treatment protocols come to completion, plans are in place for wide dissemination to researchers to continue to improve and refine the approaches, and to community providers and policymakers to ensure their implementation. Collaborative efforts with the Substance Abuse and Mental Health Services Administration and Single State Authorities (State Substance Abuse Directors) are ongoing to develop products and trainings based on research results and practitioner needs to facilitate community adoption of evidence-based practices.

Performance Measure	Fiscal Year 2006		
	Target	Actual	Result
By 2008, develop and test two new evidence-based treatment approaches for drug abuse in community settings.	Recruitment will be completed of approximately 1000 patients from specialized populations to test the efficacy of community-based treatments.	02/2007	Deferred
Data Sources: 1. Trial progress reports prepared by Data Statistics Center. 2. http://www.nida.nih.gov/CTN/protocol/brochure/2005_ctn_brochure%2010_17_05.pdf			

Result Analysis
The program met and exceeded its FY 2005 annual target. A total of 184 treatment providers, 94 more than the original target of 90, were trained in the three treatment protocols. All 184 treatment providers participated in the trials. Training is an ongoing priority to ensure the continuity of treatment in the delivery of care. Extra treatment providers were trained for two important reasons: to accommodate the requirements of shift work/service provision and in anticipation of the different turnover rates of providers at different sites.

Final and annual progress is typically due 30-90 days at the end of the fiscal year. Most findings are available on October 31 for NIH's review. The 2006 data are available between November and January and reported in the FY 2008 Congressional Justification published in February 2007.

Trends	Fiscal Year Actual				
Performance Measure	2002	2003	2004	2005	2006
By 2008, develop and test two new evidence-based treatment approaches for drug abuse in community settings.	N/A	N/A	Three treatments have been adapted for community-based settings.	The Clinical Trials Network has trained 184 providers (94 more than planned) in Brief Strategy Family Therapy, Motivational Enhancement Treatment, and Seeking Safety, which are being tested in community settings.	02/2007

Data Collection
NIH established a Data and Statistics Coordinating Center for the Clinical Trials Network program (CTN). The Data and Statistics Coordinating Center is a system for data collection, management, and quality assurance. For each trial, it collects data from Case Report Forms that are received directly from practitioners and kept at the DSC. The data must conform to predetermined parameters described in the written protocols. Queries are generated centrally by the Data and Statistics Coordinating Center for any data that are outside these parameters, and sent to both the sites and the Principal Investigator for resolution. Data on Case Report Forms are matched to patient records by local site monitors and by national monitors sent from the CTN's Clinical Coordinating Center. The Clinical Coordinating Center was established as an independent contract institution to provide resources and regulatory support with review and quality assurance monitoring. On-site monitoring by the Clinical Coordinating Center usually occurs every three months or more often as needed for the particular trial. At the completion of the trials, all data are verified by the Clinical Coordinating Center and the Data and Statistics Coordinating Center before data lock.

Completeness
Final data sets are audited by on-site monitors matching Case Report Forms with the electronic data base. Data are also reviewed by monitors from the independent Clinical Coordinating Center that conducts quality assurance monitoring for the program nationally. An in-person site visit is scheduled for close-out of the site. In addition, the data are released after they are used in scientific publications, so accuracy and completeness are assured.

Reliability
The reliability of this program's performance data is ensured by the Data and Statistics Coordinating Center and the Clinical Coordinating Center. The Data and Statistics Coordinating Center ensures that the data conform to the predetermined parameters and that non-conformance is tracked and submitted to the site for resolution. The conduct and compliance of the treatment protocols is ensured by the Clinical Coordinating Center site-monitoring.

4c Knowledge Base on Chemical Effects in Biological Systems (CEBS)
National Institutes of Health (NIH)

Significance
The problems of identifying environmental factors involved in the etiology of human disease and performing safety and risk assessments of drugs and chemicals have long been formidable issues. 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 expression 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 diverse for different chemicals, scientists expect that these characteristic "signatures" of exposure and effects will be useful in classifying these chemicals and other stressors by their 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, a knowledge base on Chemical Effects in Biological Systems (CEBS) is being established. CEBS will contain data on global gene expression, protein expression, metabolite profiles, and associated chemical/stressor-induced effects in multiple species.

The achievement of this performance goal 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 (e.g., Food and Drug Administration), pharmaceutical companies and the chemical industry. The success of the CEBS will greatly improve scientists' ability to identify environmental factors involved in the etiology of human disease and perform safety and risk assessments of drugs and chemicals.

Once CEBS is complete, there will be a number of benefits to society. Among these potential benefits is the ability to better assess the safety of drugs, evaluate the hazards and risks of exposures to environmental agents, and better treat disease caused by environmental exposures. Furthermore, scientists will be able to improve their prediction of human health effects from chemicals and, thereby, help to increase public health by recommending how to remove or diminish these causes of disease.

Performance Measure	Fiscal Year 2006		
	Target	Actual	Result
By 2012, develop a knowledge base on chemical effects in biological systems using a systems toxicology or toxicogenomics approach.	Enhance the CEBS to allow the capture and integration of transcriptomics, proteomics, and toxicologic data for the same compound.	CEBS version 2.0.7 was released and is the first public repository designed to capture, and fully integrate with 'omics data, toxicological, histopathological and other biological measures.	Met
Data Source: CEBS website at http://cebs.niehs.nih.gov/			

Result Analysis
The program's FY 2006 annual target was met. CEBS version 2.0.7 was released on September 6, 2006 and is the first public repository designed to capture, and fully integrate with 'omics data, toxicological, histopathological and other biological measures. The scope of data captured from toxicogenomics studies includes observations made of the subject throughout the study timeline, both before and after the specimen was taken for toxicological, histopathological or other biological analysis. CEBS also captures descriptions of the protocols used in the study, in-life observations of subjects, and all associated biochemical measurements and histopathological analyses. These protocols, temporal events, and analytical measurements, are useful in integrating microarray or proteomics data with a defined patho-

physiological phenotype. Acetaminophen is an example compound for which all mentioned datatypes have been integrated within CEBS.

Trends	Fiscal Year Actual				
Performance Measure	2002	2003	2004	2005	2006
By 2012, develop a knowledge base on chemical effects in biological systems using a systems toxicology or toxicogenomics approach.	N/A	ProtoCEBS launched.	CEBS now has a data portal that loads toxicology data. CEBS can import, export, and link molecular expression data to toxicology/ pathology fields.	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.	CEBS version 2.0.7 was released and is the first public repository designed to capture, and fully integrate with 'omics data, toxicological, histopathological and other biological measures.

Data Collection
Data is currently solicited from government, commercial, or academic sources. Most are reference datasets that have been peer-reviewed and published. Papers and submitted data are reviewed by the CEBS curator who abstracts essential metadata to accompany the data; files are compared with publications and additional metadata are collected from the submitters to meet all CEBS data documentation standards.

Completeness
Data and metadata are entered by the curator as a series of CEBS standard files into the CEBS loader which performs automated checks of data integrity and completeness. The curator responds to any automated error messages that are generated in the loading process. The dataset is then visualized in the CEBS load by the curator. Once the dataset has been visually verified, a standard set of files is uploaded into pre-production CEBS. There are additional automated data-integrity and completeness checks at this stage. Finally, the depositor of the data performs the final data check for completeness and validity, as well as conformance with intended data presentation objectives. Any issues identified in pre-production are corrected before the dataset is deployed. CEBS business-rules that are applied throughout the curation and data loading process tend to minimize any limitations in the data. If the data is not complete, computationally-intact, and well-documented, it does not get deployed in production CEBS.

Reliability
Microarray data pass through a series of automated integrity checks, as well as manual verification if the data fails the test. The study design and toxicity data are checked for format validity, and spot-checked for integrity prior to upload into CEBS. A final check for data integrity is performed by the depositors of the data within the "private" mode of CEBS before the data are released to the public.

STRATEGIC GOAL 5:
Improve the Quality of Health Care Services

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 strategic 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.

HHS makes available 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.

This strategic goal highlights four programs including FDA's Medical Product Surveillance Network, FDA's Human Drugs program, Agency for Healthcare Research and Quality's (AHRQ) Prevention Portfolio, and AHRQ's Health IT.

Highlighted Programs

- 5a: FDA Medical Product Surveillance Network
- 5b: FDA Human Drugs Program
- 5c: AHRQ Health IT
- 5d: AHRQ Prevention Portfolio

5a Medical Product Surveillance Network (MedSun)
Food and Drug Administration (FDA)

Significance
The MedSun Network was created to reduce device-related medical errors; serve as an advanced warning system; and create a two-way communication channel between FDA and the user-facility community. The MedSun program is designed to train hospital personnel to accurately identify and report injuries and deaths associated with medical products.

Performance Measure	Fiscal Year 2006		
	Target	Actual	Result
Expand actively participating sites in MedSun Network to 71 percent	71%	86%	Met
Data Source: Center for Devices and Radiological Health, Adverse Events Reports			

Result Analysis
FDA has achieved the MedSun targets for the last four years, and has successfully built a system of 350 facilities. Beginning in FY 2006, FDA is turning its focus from building the system to increasing the participation rate of the facilities in the system.

Trends	Fiscal Year Actual				
Performance Measure	2002	2003	2004	2005	2006
Expand actively participating sites in MedSun Network to 71 percent	80 facilities	206 facilities	299 facilities	354 facilities	86%

Data Collection
FDA uses the services of a contractor to assist with administering the program. The contractor provides reporting assistance, processes reports submitted by participating hospitals, and subsequently releases the reports to FDA and the manufacturers. The contractor also supplies MedSun hospitals with feedback concerning the reports and FDA's use of the data. The report data is held in a database behind FDA's firewall.

Completeness
FDA receives weekly and quarterly reports from the contractor, which assists FDA in monitoring the program. There are regularly scheduled and ad hoc meetings as well that supplement the monitoring. In addition, FDA and the contractor conduct an annual survey of the sites that are participating.

The contractor sends a thank-you response to each reporter when a report is received and follows up with the reporters to ensure the data is complete and accurate. The contractor may edit the report to ensure completeness and then the report is released to the FDA for action.

Reliability
Before a facility is given access to the MedSun system, representatives that will be using the system are required to undergo an orientation program. During the orientation program, MedSun users are required to sign security rules for the system which include password and user-id rules and a designation that the MedSun reports will fulfill the reporting requirements for the Safe Medical Devices Act of 1990. Representatives that generally sign the forms are the risk manager, the biomedical engineer, patient safety officer, or quality assurance people (typically there are two representatives from each site). After the users have attended the orientation, the representatives are given a user-id and password. If a facility decides to leave the MedSun program, that facility is removed from the tracking system and the representative(s) passwords are inactivated.

The contractor maintains a tracking database with detailed information on the user facilities such as size, number of reports submitted, and region. The contractor may enter the name, address, and other facility identifiers to the database, however only one person is tasked with maintaining the tracking database from which all administrative reports are generated. No duplicates can appear in the tracking database because it is programmed to reject duplicates. If a site does not submit a report within six- months, the contractor contacts the facility to follow-up.

5b Human Drugs Program
Food and Drug Administration (FDA)

Significance
FDA's review of Priority New Drug Applications (NDAs) makes a crucial public health impact on thousands of Americans with serious health conditions waiting for important new drug remedies. Priority NDAs, as opposed to Standard NDAs, represent drugs that offer significant treatment or public health advances over existing treatments. For example, drugs for AIDS and cancer typically fall into the priority category. By committing to review and act on priority applications in only six months instead of the standard ten months, FDA ensures that any promising new treatments that are deemed safe and effective reach the public as soon as possible.

Performance Measure*	Fiscal Year 2006		
	Target	Actual	Result
Percentage of Priority NDAs reviewed within six months.	90%	10/2007	Deferred
Data Source: Center-wide Oracle Management Information System and New Drug Evaluation/Management Information System			

*"Reviewed" has been added for clarity and is not the exact wording used in the FY 2007 Congressional Justification.

Result Analysis
There will be at least a six month lag before FY 2006 actual data will be available, since applications that are submitted to FDA at the end of fiscal year need to be reviewed before the performance data can be calculated. However, FDA has consistently met this goal in the past, and the timely achievement of high-quality drug reviews in recent years reflects the importance of managerial reforms and substantial additional resources provided under the Prescription Drug User Fee Act (PDUFA).

Trends	Fiscal Year Actual				
Performance Measure	2002	2003	2004	2005	2006
Percentage of Priority NDAs reviewed within six months.	100%	100%	96%	10/2006	10/2007

Data Collection
FDA has a detailed process in place for tracking information related to PDUFA goal dates. Meta data about the application itself, the date of receipt, review assignments, activities, and actions are all captured in a corporate management information system. Staff are trained on how to enter data and there are quality assurance methods used to ensure the accuracy of the data entered.

Completeness
Data collection and entry procedures for tracking applications and PDUFA goal dates are very detailed and thorough. The software applications tied to the corporate management information system have built in security and data quality control mechanisms. These internal controls combined with training and standard operating procedures available to staff entering data serve as tools to validate and verify the completeness and accuracy of data.

Reliability
PDUFA goal date performance is highly scrutinized by all levels of management at FDA. The numbers of priority applications reviewed and acted upon at FDA each year are manageable (typically only a few dozen annually). Management are aware of the applications and timeframes of actions, and therefore, will be very aware of the rare instances when a priority application will miss a PDUFA goal date. In that way, management awareness serves as another layer of quality check in the reliability of the data reported about priority NDAs from the corporate information system.

5c Health IT
Agency for Healthcare Research and Quality (AHRQ)

Significance
In "Crossing the Quality Chasm" (2001), the Institute of Medicine emphasized the importance of improved health care delivery systems to improved health outcomes, and called out health information technology (HIT) as an innovation that supports such improvement. Other recognized studies and reports contain similar findings.

AHRQ's current HIT portfolio is comprised of grants and contracts designed to explore strategies for successful planning and implementation of HIT and accompanying interventions in communities, and to demonstrate the value of HIT to improved patient safety, quality, and costs of care. These goals underlie the President's desire to have electronic health records (EHRs) for most Americans by 2014. AHRQ's HIT projects span the spectrum of HIT adoption, with a particular focus on small and rural practices. This research is foundational to building a nationwide electronic health information exchange (HIE) network, which is necessary for supporting robust personal health records (PHRs) and EHRs, clinical decision support, health research, and population health. For example, by capturing high-quality clinical and administrative data electronically and storing it in standardized form, and by using secure and appropriate ways to access such data across settings, a PHR or EHR will be able to provide more complete critical information to health professionals at the point of a patient's care, thereby reducing errors and improving care quality.

Performance Measure	Fiscal Year 2006		
	Target	Actual	Result
By 2014, most Americans will have access to and utilize a Personal Electronic Health Record (EHR)	AHRQ will partner with one major HHS Operating Division to expand the capabilities of the EHR	Pursuant to American Health Information Community (AHIC) May 2006 recommendation, AHRQ is collaborating with Centers Medicare and Medicaid Services (CMS) to support faster development of improved Personal Health Records (PHR)	Met
	The core capabilities and function of the Personal Health Record (PHR) will be delineated	AHRQ is participating fully in the AHIC Consumer Empowerment Workgroup activities to establish the core capabilities of PHRs 2006 is defining key elements of a PHR	Met
Data Source: http://www.hhs.gov/healthit/documents/Presentations051606.pdf - goal 1 - slide 40 http://www.hhs.gov/healthit/ahic/ce_archive.html - goal 2 - page 30, recommendation 19 http://www.hhs.gov/healthit/ahic/ce_materials.html - goal 2 - Workgroup Member List			

Result Analysis
AHRQ has met its goals through participation in the Consumer Empowerment Workgroup of the American Health Information Community (AHIC) and through implementing the recommendation of the AHIC to partner with the Centers for Medicare and Medicaid Services (CMS) to improved Personal Health Records and Electronic Health Records. The program was implemented in FY 2005 and no historical data exist before that time.

Trends	Fiscal Year Actual				
Performance Measure	**2002**	**2003**	**2004**	**2005**	**2006**
By 2014, most Americans will have access to and utilize a Personal Electronic Health Record (PHR)	N/A	N/A	N/A	AHRQ funded a phased EHR improvement that implemented interoperability with other public/private providers.	Pursuant to AHIC May 2006 recommendation, AHRQ partnered with CMS on PHR technology

Data Collection
For the first goal, the recommendation was discussed and adopted at the AHIC meeting on May 16, 2006. For the second goal, records of the Consumer Empowerment Workgroup of the AHIC were used.

Completeness
AHRQ's collaboration with CMS to advance personal health records comes at the direction of HHS Secretary Michael O. Leavitt. AHRQ offers publicly available meeting minutes as data that verifies that order in a complete way. The AHIC meeting on May 16th, 2006, the Electronic Health Record Workgroup recommended that: "HHS, through CMS, AHRQ, other interested Federal agencies, and private-sector partners, should pilot programs that measure and demonstrate the value of an electronic registration summary and medication history to patients with chronic disease and their clinicians. The sponsoring organizations should strive to implement pilot programs that meet all the objectives identified by the Workgroup no later than December 31, 2006, and an evaluation of the initial results should be reported to the Community by June 30, 2007." This recommendation was adopted by Secretary Leavitt. We have had subsequent meetings and email discussions to develop this collaboration.

Reliability
Data to support the achievement of both goals is found in the records of the AHIC, an entity subject to the Federal Advisory Committee Act. AHIC meetings are open and the records are publicly available. Data is verified against transcripts, proceedings and minutes of the meetings referenced.

5d Prevention Portfolio
Agency for Healthcare Research and Quality (AHRQ)

Significance
The mission of the Prevention Portfolio is to increase the adoption and delivery of evidence-based clinical prevention services to improve the health of all Americans. We seek to accomplish our mission through two main avenues: work in support of the United States Preventive Services Task Force (USPSTF), and Portfolio efforts aimed at dissemination and implementation of the Task Force's recommendations. As the USPSTF makes evidence based recommendations, it is AHRQ's job to disseminate information to clinicians and the general public as quickly as possible. Accomplishing this more quickly puts actionable information into the hands of clinicians, guiding them to perform indicated services and not to perform services for which the evidence indicates more harm than benefit. The benefit of disseminating information is increasing delivery of appropriate clinical preventive services.

Performance Measure	Fiscal Year 2006		
	Target	Actual	Result
Measure #1: Increase the quality and quantity of preventive care delivered in the clinical setting especially focusing on priority populations	Establish baseline for reach of evidence-based preventive services through use of products and tools.	1.)Views and downloads of electronic content: • USPSTF recommendations: 4,242,074 • General Preventive services: 1,621,848 • Preventive Services Selector tool: 13,496 • National Guideline Clearinghouse related to USPSTF recommendations: 359,634* 2.) Dissemination of published products: • 2005 Clinical Guide: 11,021 • Consumer products: 352,216 • Adult Preventive Care Timeline: 1,819 • Journal publications: - Pediatrics, 2 publications, circulation 63,000 - Annals of Internal Medicine, 1 publication, circulation 92,756	Met
Measure #2: Improve the timeliness and responsiveness to the USPSTF	Decrease the median time from topic assignment to recommendation release.	Four topics released to date in FY 2006, time from assignment to release ranged from 14 to 30 months, median time 25 months.	Met
Measure #3: Increase the number of partnerships that will adopt and promote evidence-based clinical prevention	Increase the number of partnerships adopting evidence-based clinical prevention by 5%	**Federal partners** – 10 **Non-Federal partners** - 10 Primary Care Orgs - 2 Health Care Insurance Industry - 2 Consumer Organization - 3 Employer Organizations - 6 Other organizations	Met

Data Source: Web trends, AHRQ Publications Clearinghouse, National Guideline Clearinghouse, Preventive Services Selector Tool, Evidence Based Practice Center task order documents, and the Prevention Portfolio's tracking database of USPSTF topics for management purposes.

* Data for the National Guideline Clearinghouse are for 7/1/05 - 6/30/06

Result Analysis

AHRQ has met the target for Measure #1 - Establishing baseline date for the reach of evidence-based preventive services through use or products and tools - by collecting data from several sources including AHRQ website data from the Office of Communication and Knowledge Transfer (OCKT), views and downloads on the USPSTF recommendations on the National Clearinghouse website, and data on distribution of printed materials via the AHRQ Publications Clearinghouse. For Measure #2 – Decrease the median time from topic assignment to recommendation release – this target was met through processes that are either internally maintained by the Prevention team through use of task order documents from the Evidence Practice Centers, internal work tracking databases for the team, or are a matter of public record (e.g. date of publication of a manuscript in a medical journal). Measure #3 – increase the number of partnerships promoting evidence-based clinical prevention by 5 percent - was met by obtaining a count of active partnerships with the Prevention Portfolio in FY 2006. This count was derived from Agency documentation of portfolio activities.

Trends	Fiscal Year Actual				
Performance Measure	**2002**	**2003**	**2004**	**2005**	**2006**
Measure #1: Increase the quality and quantity of preventive care delivered in the clinical setting especially focusing on priority populations	N/A	N/A	Expert opinions regarding best practices for delivering clinical preventive services obtained through stakeholder meetings and focus groups. Developed Train the Trainer program	**Cervical Cancer**: - % of women (18+) who report having had a Papanicolau smear within the past 3 years – 81.3% **Colorectal Cancer:** - % of men & women (50+) report they ever had a flexible sigmoidoscopy/colonoscopy – 38.9% - % of men & women (50+) who report they had a fecal occult blood test (FOBT) within the past 2 years – 33%	1.)Views and downloads of electronic content: • USPSTF recommendations: 4,242,074 • General Preventive services: 1,621,848 • Preventive Services Selector tool: 13,496 • National Guideline Clearinghouse related to USPSTF recommendations: 359,634*

				Cardiovascular Disease: - % of people (18+) who have had blood pressure measured within preceding 2 years and can state whether their blood pressure is normal or high – 90.1% - % of adults (18+) receiving cholesterol measurement within 5 years – 67.0%	2.) Dissemination of published products: • 2005 Clinical Guide: 11,021 • Consumer products: 352,216 • Adult Preventive Care Timeline: 1,819 • Journal publications: - Pediatrics, 2 publications, circulation 63,000 - Annals of Internal Medicine, 1 publication, circulation 92,756
				Cardiovascular Disease and Cancer: - % of smokers receiving advice to quit smoking – 60.9%	
Measure #2: Improve the timeliness and responsiveness to the United States Preventive Services Task Force	N/A	N/A	N/A	**9 recommendations** released **78% current** within National Guideline Clearinghouse standards (reviewed within 5 years) **100% of recommendations** related to Institute of Medicine priority areas for preventive care current within National Guideline Clearinghouse standards **Develope**d new topic criteria, submission, review, and prioritization processes with new USPSTF topic prioritization workgroup	Four topics released to date in FY2006, time from assignment to release ranged from 14 to 30 months, median time 25 months.

Measure #3: Increase the number of partnerships that will adopt and promote evidence-based clinical prevention	N/A	N/A	Produced fact sheets Partnered with professional societies and advocacy groups	**Federal partners** – 8 **Non-Federal partners** - 10 Primary Care Organizations - 2 Health Care Delivery Organizations - 1 Consumer Organization - 3 Employer Organizations - Other organizations – 3	**Federal partners** – 10 **Non-Federal partners** - 10 Primary Care Organizations - 2 Health Care Insurance Industry - 2 Consumer Organization - 3 Employer Organizations - 6 Other organizations

Data Collection
Measure #1: USPSTF data is captured using a statistical package – Web trends. This process captures downloads for specific pages and the numbers are automatically generated and compiled. AHRQ Publications Clearinghouse dissemination data is maintained by the Clearinghouse with records for requests and shipments. AHRQ maintains internal records of actual Government Printing Office publication printings and delivery receipts. National Guideline Clearinghouse data is captured on website hosted by ECRI (formerly Emergency Care Research Institute). The Preventive Services Selector Tool is hosted on web site by EEI Communications.

Measure #2: Evidence Based Practice Center task order documents, including Monthly Status Reports are maintained by the Prevention Portfolio; copies are part of the Evidence-based Practice Center contract files. AHRQ Prevention Portfolio staff maintains a password-protected tracking database of USPSTF topics for management purposes.

Prevention team leaders (Drs. Miller and Barton) participate in a bi-weekly conference call with the EPC contractors during which time task order documents and monthly status reports are reviewed and data verified. For work that is internal to AHRQ (for example the release of a USPSTF recommendation and accompanying evidence review only through our website) the weekly Prevention team meetings are used to review and verify data about decisions such as when to publish, what format to use, etc. Electronic mail provides a record of drafts of documents during the editing process and dated near-final and final drafts of documents are saved in a structured way on the team's computer drive which is accessed by team members from OCKT and CP3.

Measure #3: AHRQ Prevention Portfolio staff maintains internal tracking documents of partnerships including IAAs and other contractual documents, and a password-protected tracking database of prevention partners/activities for management purposes.

Completeness
The methodology and rationale used to determine recommendations are published in peer- reviewed journals to insure transparency and to further the field of evidence-based practice. Dissemination of the recommendation is accomplished by print and electronic publication and by the creation of new products and tools directed at specific audiences. Developing and sustaining public and private partnerships are important steps for the Portfolio in effectively and efficiently facilitating the use of evidence-based recommendations and effective delivery system designs.

- Measure #1 - the data as shown is current through the end of June 2006, unless otherwise specified.
- Measure #2 – these data are completed with a high degree of confidence as they represent processes that are either internally maintained by the Prevention team (e.g. task order -documents from the

Evidence Practice Centers, internal work tracking databases for the team) or are a matter of public record (e.g. date of publication of a manuscript in a medical journal).

- Measure #3 – these data are completed with a high degree of confidence as they represent partnerships that are developed and maintained by the Prevention team.

Reliability
Measures #1: For website tracking, information is generated and tallied in a spreadsheet, with a breakout for recommendations and all other Preventive Services materials. A documentation specialist does the special tabulation, which is then reviewed and verified by our lead programmer. This data is then sent to the Electronic Dissemination Advisor for final review and approval for release.

Measures #2 and #3: Data is verified against transcripts, proceedings, and Agency documentation of portfolio activities. The Prevention Portfolio uses both printed as well as computer-saved documents such as agendas for conference calls whenever possible in order to track relationships with external partners. The Prevention Portfolio calendar, saved in Outlook, serves as one source of confirmation. Electronic mail correspondence, saved in mail folders specific to the project or partner, serve as records of ongoing work and consultation. The Prevention Portfolio provides highlights for the CP3 Biweekly Report to the Agency Director, which serves to document main accomplishments (such as the publication of a joint project from the USPSTF/Prevention Portfolio from AHRQ, and the Advisory Council on Immunization Practices from the CDC). In addition, where new products are a result of partnerships with external organizations, copies of the actual product serve to document the collaboration.

STRATEGIC GOAL 6:

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

HHS promotes and supports interventions that help disadvantaged and distressed individuals, families, and communities improve their economic and social well-being. To achieve this strategic goal, HHS targets 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.

This report highlights two programs that contribute to achieving this strategic goal including the Administration for Children and Families' (ACF) Temporary Assistance for Needy Families (TANF) program and Administration on Aging (AoA) Services Program.

HHS partners with community and faith based organizations to make available services to individuals and communities in need. ACF's Office of Family Assistance and AoA's Aging Services program illustrate HHS' commitment to self-sufficiency. ACF's TANF program promotes work and self-sufficiency to improve the economic well-being of individuals and families through various state- and Tribal-administered programs. The Aging Services program ensures that local services are provided to seniors who are at risk of losing their independence.

Highlighted Programs

- 6a: ACF Temporary Assistance for Needy Families
- 6b: AoA Aging Services Program

6a Temporary Assistance for Needy Families (TANF)
Administration for Children and Families (ACF)

Significance
The Temporary Assistance for Needy Families (TANF) is a time limited block grant program that focuses on work and responsibility. States have broad flexibility in the design of their programs including setting eligibility rule and the extent of benefits and services provided to families. Under TANF, adults receiving assistance are expected to engage in work activities and develop the capability to support themselves and their family before the time-limited assistance runs out. States are required to assist recipients in making the transition to employment.

The TANF Job Retention Rate is one of several work-related measures. It measures the unduplicated number of employed adult recipients in each quarter of the performance year who were also employed in the first and second subsequent quarters. (At some point, the adult might have become a former recipient). This goal is important because it is through employment that recipients gain skills, become self-reliant, and move towards self-sufficiency. Society gains a more productive member and tax dollars are more effectively utilized.

Performance Measure	Fiscal Year 2006		
	Target	Actual	Result
Increase the percentage of adult TANF recipients/former recipients employed in one quarter that were still employed in the next two consecutive quarters.	61%*	10/2007	Deferred
Data Source: National Directory of New Hires			

*Revised target published in the FY 2007 Congressional Justification.

Result Analysis
In FY 2005, the job retention rate was 64.8 percent, missing the 68 percent target. The 68 percent target for FY 2005 did not take into consideration the dampening effect of the caseload reduction credit, which reduced recipient work participation rates. In addition, the current employment retention measure represents a more rigorous measure than the one used prior to FY 2000, because it measures job retention for a longer period of time. Whereas the previous measure assessed job retention for one subsequent quarter, the current measure looks at retention for two subsequent quarters. FY 2006 results will be available in October 2007, due to time needed for States to compile and report data and for ACF to analyze the data.

The program has revised targets for FY 2006 and out years to reflect the effects of the caseload reduction credit, as well as the changes in the definition of the performance measure. However, the targets will be updated again because of the passage of the TANF reauthorization legislation, which strengthens the work requirements to ensure adult TANF recipients are engaged in work or activities leading to employment.

Trends	Fiscal Year Actual				
Performance Measure	2002	2003	2004	2005	2006
Increase the percentage of adult TANF recipients/former recipients employed in one quarter that were still employed in the next two consecutive quarters.	59%	59%	59%	64.8%	10/2007

Data Collection
States provide quarterly lists of monthly adult recipient social security numbers, which are matched against the National Directory of New Hires (NDNH). TANF recipient data validity is ensured with normal audit functions such as the Single State Audit. The Office of Child Support Enforcement monitors/manages the NDNH system. The Office of Child Support Enforcement ensures data validity of the NDNH through various activities including error reports and data quality analyses.

Completeness
The data are limited by the fact that self-employment and some farm employment are not included in the NDNH; however, this is only a small portion of all employment.

Reliability
The TANF job entry, job retention and earnings gain employment data are derived from matching TANF adult recipient social security numbers against the NDNH wage data base. All employers are required to report quarterly wage information to the State Employment Agencies, which in turn are required to report this information to the NDNH. The NDNH wage data base is the most complete national set of wage information available and includes federal employment wages.

6b Aging Services Program
Administration on Aging (AoA)

Significance
The Aging Services program, which includes all AoA program activities, makes essential home and community-based services available across the country to elderly people and family caregivers to help keep America's rapidly growing elderly population healthy, secure and independent in the community. To accomplish this, AoA awards grants to States, Tribal organizations, and other organizations to support a network of aging service providers. Services provided to elderly people include but are not limited to: meals, transportation, caregiver support, personal care, information and assistance, nursing-home ombudsman, elder rights protection, and health promotion. This report highlights a single, fundamental measure of the performance of the aging network to reflect AoA's effectiveness in helping elderly people maintain their independence in the community.

Performance Measure	Fiscal Year 2006		
	Target	Actual	Result
Increase the number of severely disabled clients[1] who receive selected home and community-based services.	322,522 (base + 15%)	02/2007	Deferred
Data Source: National Survey of Older Americans Act Service Recipients			

Result Analysis
In FY 2005, AoA served home-delivered meals to 313,362 severely disabled elderly people, an increase of 11.7 percent over the baseline, which exceeds the FY 2005 performance target of 302,000. In FY 2004, AoA improved performance, serving home delivered meals to 293,500 severely disabled elders. It is a positive indicator that the network achieved a four percent increase in this critical performance measure in one year. In FY 2003, approximately 280,000 severely disabled elderly people received home-delivered meals, roughly 30 percent of all older individuals who received such services. In February 2007 AoA will report the FY 2006 results.

Trends	Fiscal Year Actual				
Performance Measure	2002	2003	2004	2005	2006
Increase the number of severely disabled clients who receive selected home and community-based services.	N/A	280,454 (baseline)	293,500	313,362	02/2007

Data Collection
State Agencies on Aging are required to collect, compile, and annually transmit to AoA the State Program Report which contains Older American's Act program information and data. In addition, AoA, in partnership with State and Area Agencies on Aging, conducts an annual National Survey of Recipients of Older American's Act Services to obtain consumer-reported outcome information; the research contractor conducts these National Surveys.

Completeness
AoA's National Surveys employ a range of quality assurance procedures to guarantee the validity of data on Older Americans Act participants and services. These quality assurance procedures cover all steps in the survey process, from the development of the samples of agencies and service recipients, to the computer-assisted telephone interviewing (CATI) editing that occurs during the survey, and the post-survey weighting of the data to assure the sample is truly representative of the universe of clients and services.

[1] AoA defines severely disabled elderly people as those with three or more Activities of Daily Living limitations who are therefore nursing home eligible.

After the surveys are complete, range and consistency checks and edits, in conjunction with the CATI software applications ensure that only correct responses appear in the data files. Also, the statisticians weight the data during three important post-survey steps to ensure accuracy. First the sample of agencies and clients is weighted using the universe of the probability of selection. Second, there is an adjustment for any non-response patterns and bias that might otherwise occur. Third, the data are post-stratified to known control totals to ensure consistency with official administrative records. Accompanying all survey responses are confidence intervals for measuring the precision of the survey results. This ensures that the data reported by AoA are statistically sound and a precise representation of performance in the Older Americans Act programs.

Reliability
Through the National Survey of Recipients of Older Americans Act Services, AoA focuses on the assessment of quality through consumer surveys. A highly experienced survey research firm is the contractor that conducted AoA's national surveys of service recipients and they employ numerous validation procedures to assure data quality. Survey data quality is good; survey response rates are consistently above 80 percent and the data are consistent with similar data collections conducted by state grantees. Survey results can be found at http://www.aoa.gov/about/results.

For the annual State Program Report submissions, AoA reviews the data, obtains revised submissions as needed, certifies the data and releases it to the public. Descriptive material on this report and its results are on AoA's website at http://www.aoa.gov/prof/agingnet/NAPIS/napis.asp.

STRATEGIC GOAL 7:
Improve the Stability and Healthy Development of Our Nation's Children and Youth

In order to promote the development and stability of our Nation's children and youth, HHS supports 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 aid the social and cognitive development of preschool children.

This report highlights three programs that contribute to achieving this strategic goal including Administration for Children and Families' (ACF) Child Support Enforcement, Child Welfare, and Head Start programs.

Child Support Enforcement assures that resources are available to children by locating parents and establishing paternity and support obligations. These efforts are an integral component 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 and literacy goals as well as employment goals, supporting parents' role in their children's learning, and emphasizing the direct involvement of parents in the administration of local Head Start programs.

Highlighted Programs

- 7a: ACF Child Support Enforcement
- 7b: ACF Child Welfare
- 7c: ACF Head Start

7a Child Support Enforcement

Administration for Children and Families (ACF)

Significance

The Child Support Enforcement (CSE) program's purpose is to enhance the well-being of children by assuring that assistance in obtaining support, including financial and medical, is available to children through locating parents, establishing paternity, establishing support obligations, and monitoring and enforcing those obligations. The primary customers and beneficiaries of the CSE program are children in need of support. The parents and/or custodians of these children are also customers. Child support is an important source of income for improving the quality of life for children and for families striving for self-sufficiency. Child support promotes stable, safe, and healthy relationships between parents and children by participating in the larger community's efforts to strengthen families, and encourage healthy marriage and responsible parenthood. The performance measure, child support current collection rate, serves as a proxy for the regular and timely payment of support. Additional information can be found at the CSE web site www.acf.hhs.gov/programs/cse.

Performance Measure	Fiscal Year 2006		
	Target	Actual	Result
Increase the Title IV-D collection rate (collections on current support/current support owed).	62%	11/2007	Deferred
Data Source: OCSE Form 157.			

Result Analysis

The total amount of current support due in FY 2004 was $28 billion, an approximate increase of three percent over FY 2003. 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. Combined for FY 2004, these data represent a collection rate for current support of 59 percent, which exceeded the target by one percentage point. This means that 59 percent of the child support owed in that year was collected and distributed to families.

The FY 2005 data and FY 2006 data will be available in November 2006 and November 2007 respectively because of the time it takes to conduct data reliability audits. The OCSE-157 report is to be completed by State IV-D (child support) agencies for each Federal fiscal year ending September 30. The report is due within 30 calendar days after the last day of the fiscal year. Each year all States are expected to submit complete, accurate reports by October 30. States may revise previously submitted reports by submitting new ones. All revised final reports must be received in Office of CSE by December 31 of each year.

Trends	Fiscal Year Actual				
Performance Measure	**2002**	**2003**	**2004**	**2005**	**2006**
Increase the Title IV-D collection rate (collections on current support/current support owed).	58%	58%	59%	11/2006	11/2007

Data Collection

The annual state/grantee data are reported on lines 24 and 25 of the OCSE-157 form. Edit checks are built into Grants Administration Tracking and Evaluation System when data are entered by the grantees. Data are checked annually against historical data.

Completeness

CSE is largely dependent on state administrative systems for collecting performance data. In terms of data quality and reliability, States maintain information on the necessary data elements for CSE

measures. Federal auditors from the Office of CSE evaluate whether or not state data used to calculate the performance measure are complete and accurate.

Reliability
Data reliability audits are conducted annually. Federal auditors evaluate whether or not state data used to calculate the performance measure are reliable. Self-evaluation by States and the Office of CSE audits provide an on-going review of the validity of data and the ability of automated systems to produce accurate data.

7b Child Welfare
Administration for Children and Families (ACF)

Significance
Child welfare programs seek to provide for the safety, permanency and well being of children. For children who cannot remain safely in their homes, foster care provides a safe and stable environment. If a family cannot be reunified, adoption programs work to place a child permanently with an adoptive family. The Adoption and Safe Families Act of 1997 reconfirmed the Nation's commitment to finding every child a permanent home and acknowledged that children who grow up in a safe, stable, and permanent home have improved long-term outcomes.

Performance Measure	Fiscal Year 2006		
	Target	Actual	Result
Increase the adoption rate.*	9.85%	10/2007	Deferred
Data Source: Adoption and Foster Care Analysis Reporting System			

*This revised measure and target was published in the FY 2007 Congressional Justification.

Result Analysis
In FY 2004, there were 52,000 adoptions, slightly less than the target of 53,000 for that year. In FY 2005, preliminary data indicate that there were 51,000 adoptions (the most recent year for which data is available). However, this number may increase as additional adoptions for that year are reported.[2] While the annual number of adoptions increased dramatically in the last decade (from the 26,000 adoptions in FY 1995 to 51,000 adoptions in FY 2000), the number of adoptions annually has leveled off. Data for FY 2006 will be available in October 2007.

For FY 2006, ACF revised the measure of total adoptions with a new outcome measure of an adoption rate: the annual number of adoptions divided by the number of children in foster care at the end of the prior year. The new measure takes into account the pool of children in foster care from which those children for whom adoption is appropriate are identified. This change to the measure was necessary because the number of children in foster care has declined from 567,000 in FY 1999 to 513,000 in FY 2005. The adoption rate has increased from 9.72 percent in FY 2002 to 10 percent in FY 2004, and to 9.86 percent in FY 2005, based on preliminary data. There are varied reasons for the gradual slowing in the numbers and rate of adoptions. Many of the adoptions finalized from FY 1998 through FY 2000 were children who had been in the system for a long time. With improved case-practice following the Adoption and Safe Families Act, the backlogs are being eliminated. At the same time, the age of children "waiting" to be adopted continues to increase, with almost half over the age of nine. These older children are harder to place. This reflects the child welfare system's priority for children to be raised by their parents or a relative, when the child's safety and well-being at home are no longer at risk.

Trends	Fiscal Year Actual				
Performance Measure	2002	2003	2004	2005	2006
Increase the adoption rate.*	53,000/ 9.72%	50,000/ 9.19%	52,000/ 10%	51,000/ 9.86%	10/2007

*The first number represents the number of adoptions in the year of interest; the second number represents the adoption rate, which is calculated as the number of adoptions in the year of interest divided by the number of children in care at the end of the year prior to the year of interest multiplied by 100.

[2] Adoption and Foster Care Analysis Reporting System (AFCARS) permits adoptions finalized in one year to be reported in later years. Based on previous experience, it is likely that the number of adoptions finalized in FY 2005 will increase by as many as 2,000 adoptions. Please see http://www.acf.hhs.gov/programs/cb/stats_research/afcars/trends for further information.

Data Collection
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 sent back to each state, to help the state to improve data quality. Many States submit revised data for prior submission periods.[3] The Children's Bureau conducts several AFCARS compliance reviews each year, which typically result in a comprehensive AFCARS Improvement Plan.

Completeness
To ensure a complete and accurate account of the annual number of adoptions, AFCARS permits the reporting of adoptions finalized in one year to be reported in later years. States are required to submit AFCARS data semi-annually to ACF. The AFCARS report periods are October 1 through March 31 and April 1 through September 30. Preliminary reports of AFCARS data from States are received twice annually. Interim reports include subsequent submissions to improve the quality of data, and final reports are issued when it appears that States have resubmitted data to the point that outcomes no longer can be improved. These reports may be issued three or more years after the year of interest.

Reliability
ACF has recently implemented the AFCARS Project, including a detailed review of all aspects of AFCARS by federal staff and participation of the field in identifying possible improvements. The AFCARS assessment review (AAR) process is a "validation and verification" of an automated information system. The AAR assesses the ability of a state's system to gather, extract, and submit the correct AFCARS data accurately.

[3] Since AFCARS foster care data are used in the implementation of Program Improvement Plans, resulting from the Child and Family Services Review process, States often resubmit AFCARS data to ensure that the data used for this purpose are accurate. The resubmitted data are then processed and made available to the statistical analysts as soon as possible. The analysts review the data to determine which states' data are usable in this plan.

7c Head Start
Administration for Children and Families (ACF)

Significance
Good health is an important component of school readiness, which is related to school success and later achievement. Head Start children are an economically disadvantaged population. Low-income children and families face persistent difficulty in gaining timely access to health care, with particular problems in receiving oral health care.

Performance Measure	Fiscal Year 2006		
	Target	Actual	Result
Achieve goal of at least 80 percent of children completing the Head Start program rated by parent as being in excellent or very good health.	80%	81%	Met
Data Source: Family and Child Experiences Survey			

Result Analysis
Head Start met the ambitious target of 80 percent of children completing Head Start being rated by their parents as in excellent or very good health, for FY 2006. The Office of Head Start has implemented an Oral Health Initiative in partnership with the Maternal and Child Health Bureau of the Health Resources and Services Administration. Since 2004, the Oral Health Initiative has supported a national network of technical assistance designed to improve Head Start children's access to oral health care. With this resource focused on improved oral health care access, and its continued attention to the overall health of Head Start children, Head Start expects to continue to meet the target on this measure.

Trends	Fiscal Year Actual				
Performance Measure	2002	2003	2004	2005	2006
Achieve goal of at least 80 percent of children completing the Head Start program rated by parent as being in excellent or very good health.	78%[4]	78%[5]	81%	81%	81%

Data Collection
The Family and Child Experiences Survey (FACES) is an ongoing, longitudinal study of Head Start program quality and child outcomes, which currently has three nationally representative cohorts (1997, 2000 and 2003). Data for FY 2005 and FY 2006 are the same as for FY 2004 (FACES 2003 cohort data), since the FACES data source only provides data triennially (FY 1998, FY 2001, and FY 2004). A 2006 FACES cohort is expected to begin data collection with a similar number of children and programs in fall 2006. The next new round of FACES data will be available in FY 2007.

Completeness
FACES was launched as a part of the Head Start Program Performance Measures Initiative. The goal of this initiative was to provide solid representative data on the characteristics, experiences, and outcomes for children and families served by Head Start. The use of new cohorts every three years allows the program to have continual access to up-to-date information about program performance and quality.

[4] The FY 2006 HHS Annual Plan and FY 2007 Congressional Justification report 79% as the actual result for FY 2002 and FY 2003. The correct actual result for these years is 78%.
[5] Same as above.

Reliability
The FACES study uses scientifically established methods to collect data that can be used to analyze Head Start's quality. All the measures used in FACES to measure child outcomes and program quality (including the Peabody Picture Vocabulary Test, the Woodcock-Johnson Applied Problems scale, and the Early Childhood Environment Rating Scale) have been assessed for validity and reliability, and are well-respected in the field of child development.

STRATEGIC GOAL 8:
Achieve Excellence in Management Practices

HHS is committed to improving the efficiency and effectiveness of the Department's programs by creating an organization that is citizen-based focus, results oriented, and market-driven, where practicable. 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.

This report highlights four programs that contribute to achieving this strategic goal including CMS Medicare Integrity Program (MIP), Medicaid, State Children's Health Insurance Program, and Office of Inspector General's (OIG) Health Care Fraud and Abuse Control Program. MIP ensures the right Medicare amounts are paid to a legitimate provider for an eligible beneficiary. Similarly, HCFAC conducts and supervises audits, inspections, and investigations of HHS programs and supplies guidance to the health care industry.

Highlighted Programs

- 8a: CMS Medicare Integrity Program
- 8b: CMS Medicaid and the State Children's Health Insurance Program
- 8c: OIG Health Care Fraud and Abuse Control Program

8a Medicare Integrity Program
Centers for Medicare and Medicaid Services (CMS)

Significance
One of CMS' key goals is to pay claims properly the first time. This means paying the right amount, to legitimate providers, for covered, reasonable and necessary services provided to eligible beneficiaries. Paying right the first time saves resources required to recover improper payments and ensures the proper expenditure of valuable Medicare trust fund dollars. The significance of this goal is to continue to reduce the percentage of improper payments made under the fee-for-service program as reported in the CMS Financial Report.

The complexity of Medicare payment systems and policies, as well as the numbers of contractors, providers, and insurers involved in the Medicare fee-for-service program create vulnerabilities. CMS has implemented an Error Rate Reduction Plan designed to minimize these vulnerabilities and reduce the Medicare claims payment error rate.

Performance Measure	Fiscal Year 2006		
	Target	Actual	Result
Reduce the Percentage of Improper Payments Made Under the Medicare Fee-For-Service Program	5.1 %	4.4%	Met
Data Source: Comprehensive Error Rate Testing Program and the Hospital Payment Monitoring Program			

Result Analysis
CMS began producing paid claims error rates in FY 2003 using the Comprehensive Error Rate Testing (CERT) program and the Hospital Payment Monitoring Program (HPMP). The Office of Inspector General produced error rate information for years before those included in the FY 2003 report. In FY 2004, CMS began reporting gross error rates in addition to the net error rates previously reported. In FY 2005, CMS exceeded its target of 7.9 percent with an error rate of 5.2 percent. Therefore, CMS adjusted its error rate targets downward for future years. In FY 2006, Medicare also exceeded its target of 5.1%, with an error rate of 4.4 percent.

Trends	Fiscal Year Actual				
Performance Measure	2002	2003	2004	2005	2006
Reduce the Percentage of Improper Payments Made Under the Medicare Fee-For-Service Program	6.3 %	5.8 %	10.1 %	5.2 %	4.4%

Data Collection
CMS calculates the Medicare Fee-For-Service error rate using a methodology approved by the OIG. The methodology includes:

- Randomly selecting a sample of approximately 180,000 submitted claims;
- Requesting medical records from providers who submitted the claims; and
- Reviewing the claims and medical records for compliance with Medicare coverage, coding, and billing rules.

Completeness and Reliability
The data for this program are complete and reliable. CMS and the CERT contractors and HPMP contractors audit the data through ongoing quality control measures that include comparison of the number of claims in the CERT and HPMP universe (i.e., all claims Medicare contractors receive) to an independent CMS report of the number of claims Medicare contractors received and verification that paid amounts for sampled claims match independent CMS records of claims payments. The data are audited through the CMS Chief Financial Officer Report.

8b CMS Medicaid and the State Children's Health Insurance Program (SCHIP)
Centers for Medicare & Medicaid Services (CMS)

Significance
CMS implemented the Payment Error Rate Measurement (PERM) program to comply with the Improper Payments Information Act (IPIA) of 2002 (P.L. 107-300).[6] In FY 2006, CMS implemented the PERM program in 17 States, using a national contracting strategy, to produce a Medicaid fee-for-service (FFS) error rate, which will be reported in the FY 2007 Performance and Accountability Report (PAR). In FY 2007, we plan to measure improper payments in the FFS, managed care, and eligibility components of Medicaid and SCHIP and report the national program error rates in the FY 2008 PAR.

The benefits to achieving these goals are that CMS will become fully compliant with the IPIA and States will be able to glean information from the reviews that can be used to formulate corrective actions designed to reduce improper payments in these programs. The value added to society is that the measurement will help to ensure that individuals and families are receiving the program benefits for which they are eligible.

Performance Measure	Fiscal Year 2006		
	Target	Actual	Result
Estimate the payment error rate in the Medicaid and SCHIP	Begin to implement error measurement for Medicaid fee-for-service in 17 States.	9/2007	Deferred
Data Source: Payment Error Rate Measurement Program.			

Result Analysis
The PERM program is a new program designed to produce national Medicaid and SCHIP error rates for each fiscal year measured. CMS met the target to implement the program in FY 2006 to measure Medicaid FFS error rates using a national contracting strategy. The results of this measurement, the national Medicaid FFS error rate, will be available September 2007.

Trends	Fiscal Year Actual				
Performance Goal	2002	2003	2004	2005	2006
Estimate the payment error rate in the Medicaid and SCHIP	N/A	N/A	N/A	N/A	9/2007

Data Collection
In FY 2006, CMS implemented the PERM program to measure improper payments in Medicaid FFS using a national contracting strategy. The contractors gather adjudicated claims data and medical policies from the States. The adjudicated claims are used to draw a sample of claims for review. The medical policies are used to guide the reviewers to a determination that the payment was correctly or incorrectly made based on medical necessity and appropriateness.

Each year 17 States will participate in the Medicaid measurement. At the end of a three-year period each State will have been measured once and will rotate in that cycle in future years (e.g., the States selected in year one will be measured again in year four).

[6] The IPIA requires each executive agency, in accordance with the Office of Management and Budget (OMB) guidance, to annually review all programs that it administers and identify programs that may be susceptible to significant improper payments. For those programs that are at risk, the agency shall estimate the annual amount of improper payments, and submit those estimates to Congress. OMB identified Medicaid and SCHIP as programs at risk for significant improper payments.

Completeness
The claims data collected from the States are reviewed by the Federal contractor for completeness. The contractor uses the State's prior fiscal year's expenditure data to determine if the universe and strata for each quarter's claims submission appears complete. The contractor also compares claims from each subsequent quarter to claims from the previous quarter(s).

The contractor also reviews the claims data to determine whether the data includes needed information, e.g., the payment dates are within the quarter, paid amounts are included; the categories of service correspond to the correct strata.

Reliability
The sample selected from the claims data from each State is designed to ensure a State-specific program error rate that meets a 95 percent confidence level with +/- 3 percent precision. The States' error rates will be used as the basis for the national Medicaid FFS error rate that we expect will meet the confidence and precision requirements in OMB guidance.

8c Health Care Fraud and Abuse Control Program (HCFAC)
Office of Inspector General (OIG)

Significance
The primary function of the OIG is to detect and prevent fraud and abuse and to recommend policies designed to promote economy, efficiency, and effectiveness in the administration of HHS and its programs. OIG accomplishes its purpose by conducting and supervising audits, inspections, and investigations of HHS programs, and providing guidance to the health care industry. Over 80 percent of FY 2006 OIG resources were devoted to combating fraud and abuse in health care, one of the largest segments of the United States economy and the largest programs under HHS management. OIG carries out its work through the Health Care Fraud and Abuse Control Program (HCFAC) of the Health Insurance Portability and Accountability Act of 1996, the Medicare Prescription Drug, Improvement and Modernization Act of 2003, and the Medicaid Integrity Program of the Deficit Reduction Act of 2005. The remaining OIG resources are devoted to other programs, including HHS public health and human services programs and general departmental oversight.

Return on Investment (ROI) is a performance measure that reveals the effectiveness and efficiency of OIG in helping to restrain the rising cost of the most expensive programs managed by HHS. It is a ratio that directly links the cost of operating the OIG to the financial savings to society that its audits, inspections, and investigations were instrumental in helping to bring about. Inasmuch as (1) it is impossible to predict the timing or amount of court ordered fines, penalties, restitution, out of court settlements, and audit disallowances, and (2) it takes several years for any specific instance of OIG work to show monetary results, substantial year to year fluctuation is inevitable. OIG addresses this by using annualized three-year moving averages for reporting monetary targets and documented results.

Performance Measure	Fiscal Year 2006		
	Target	Actual	Result
Return on Investment (ROI)[7]	$11.9:1	$12.9:1	Met
Data Source: Department of Justice and HHS data systems that track judicial and administrative obligations and audit receivables required to be paid to the Federal government			

Result Analysis
OIG's annualized $12.9:1 Return on Investment for the three-year period ended September 30, 2006 surpassed the target of $11.9:1. This was achieved by documenting $2.391 Billion of identified expected recoveries (the "return") for FY 2006,. When the FY 2006 result is added to the FY 2004 and FY 2005 identified expected recoveries of $2.760 Billion, and $2.883 Billion, respectfully, the return for the three-year period ended September 30, 2006 averages $2.678 Billion per year. The average annual "investment" in the OIG over this period was $207.8 Million. The historical annualized three-year moving averages of actual results for the years ending FY 2002 to 2006 are in the following table

Trends	Fiscal Year Actual				
Performance Measure	**2002**	**2003**	**2004**	**2005**	**2006**
Return on Investment (ROI)	$18.2:1	$12.1:1	$10.5:1	$11.6:1	$12.9:1

[7] The returns used for calculating ROI were redefined last year to exclude savings estimates scored by the Congressional Budget Office or HHS from enactment of legislation or adoption of administrative changes recommended by OIG. The returns are now limited to identify and document expected recoveries of funds that result from: (1) investigations that led to successful prosecutions of fraud or out of court settlements, and (2) audit disallowances.

Data Collection and Completeness
Actual expected recoveries that resulted from OIG investigations are identified by tracking cases as they proceed through the Department of Justice for a judicial decision or out of court settlement. Audit disallowances that are resolved and result in obligations to repay the Federal government are identified from the HHS audit resolution tracking system. These data collection sources are considered complete and accurate for tracking obligations to pay judicial and audit resolution obligations to the Federal government.

Data Reliability
The source data used for these results are the following: expected recoveries from investigations are entered into the OIG investigations data system "IRIS." Documents that officially report the conclusion of criminal and civil proceedings, including the amount of fines, penalties, and restitution must be received by OIG before the expected recoveries are allowed into the IRIS system. Audit disallowances are entered into the OIG WEB AIMS system by the Audit Resolution staff of the HHS Office of the Assistant Secretary for Resources and Technology, and are reconciled to the OIG audit disallowance issuances. The data have been audited in the past by the Government Accountability Office (GAO) and are available for GAO audit at any time.

Program Assessment Rating Tool

The Program Assessment Rating Tool (PART) was developed to assess and improve the performance of Federal programs, and to inform funding and management decisions aimed at increasing program effectiveness. The PART reviews of HHS programs help identify each program's strengths and growth areas through a comprehensive analysis of the program's purpose and design; performance measurement, evaluation, and strategic planning; program management; and program results. The consistent series of analytical questions allows programs to show improvements over time, and allows comparisons to be made between similar programs.

The following tables summarize the PART assessments performed during CY 2002-CY 2005. CY 2006 PART reviews will be published in February 2007. The tables are summarized in alphabetical OPDIV order by Strategic Goal. Further detail on each of these programs can be found at www.expectmore.gov.

Strategic Goal 1: Reduce the Major Threats to the Health and Well-being of Americans

Centers for Disease Control and Prevention

HHS Strategic Goal: *1*	*317 Immunization Program*
PART Rating	CY 2002: Adequate
Lead Agency	Centers for Disease Control and Prevention
PART Finding	The 317 Immunization program is successful in improving immunization coverage rates among children. Sizable reductions in disease incidence have been seen for varicella (chickenpox) among young children in the past ten years. After the implementation of the universal childhood varicella vaccination program in 1995, the incidence of disease among children ages 1-4 years declined 92 percent.
Key Follow-up Action	Conducting an evaluation and working with grantees to better measure outcomes and allocate resources based on more clear criteria.
Action Taken	Phases I and II evaluation reports have been completed and Phase III is underway. The scope of work was revised slightly to ensure there was no overlap in phase III with phases I and II. Phase III will assess program differences in performance and identify practices that may be related to performance success and efficiencies.

HHS Strategic Goal: *1*	*Domestic HIV/AIDS Prevention*
PART Rating	CY 2002: Results Not Demonstrated
Lead Agency	Centers for Disease Control and Prevention
PART Finding	The program has made progress on reducing new infections from 120,000 in the late 1980's to 40,000 in the mid-1990's, but this level has not changed for several years. The program developed new annual indicators to measure progress on long-term goals.
Key Follow-up Action	Holding managers accountable by linking achievement of target levels to employee performance plans and improving oversight of grantee activities through the Program Evaluation Monitoring System.
Action Taken	Completed: Both civilian managers' and Commissioned Corps managers' work plans have been modified to link employee performance plans with program performance.

HHS Strategic Goal: *1*	*Chronic Disease - Breast and Cervical Cancer*
PART Rating	CY 2002: Adequate
Lead Agency	Centers for Disease Control and Prevention
PART Finding	The program provides important health screenings to a population that would otherwise not receive these services.
Key Follow-up Action	Will work on developing outcome-oriented long-term measures and more ambitious long-term goals.
Action Taken	Performance targets were increased in accordance with data submitted by NBCCEDP state programs. Evaluation plan outcome measures were further developed and priorities for evaluation activities were identified.

HHS Strategic Goal: *1*	*Chronic Disease - Diabetes*
PART Rating	CY 2003: Adequate
Lead Agency	Centers for Disease Control and Prevention
PART Finding	The program has adopted performance measures.
Key Follow-up Action	Will work to develop the program's long-term health outcome goals.
Action Taken	The program has developed two long-term outcome measures as a result of completing a study on projections of lower extremity amputations.

HHS Strategic Goal: *1*	*Agency for Toxic Substances and Disease Registry*
PART Rating	CY 2004: Adequate
Lead Agency	Agency for Toxic Substances and Disease Registry (ATSDR)
PART Finding	The program has improved operating efficiency.
Key Follow-up Action	ATSDR will continue to develop measures with its partners to measure the impact on the human health risks or disease by the program.
Action Taken	ATSDR has established the FY 2004 baseline for its long-term outcome measure, as well as providing three years' worth of performance data for its measures regarding acceptance of its recommendations and filling data needs.

HHS Strategic Goal: *1*	*Occupational Safety and Health*
PART Rating	CY 2004: Adequate
Lead Agency	Centers for Disease Control and Prevention
PART Finding	The program works to address and prevent occupational hazards that result in disabling injuries, disease and/or death.
Key Follow-up Action	National Institute of Occupational Safety and Health (NIOSH) will use performance information from its research efforts to help improve program direction, allocate resources and develop annual budgets.
Action Taken	NIOSH has developed a novel governance structure to support the 30 programs of research in its Program Portfolio. A program manager and coordinator (and steering committee) will ensure the relevance of program goals and ensure that the program's research activities are of the highest scientific quality. They will also ensure the program outcomes have research-to-practice impact. Resource allocations will be determined based on the results of these activities and reviewed on an annual basis.

HHS Strategic Goal: *1*	*Infectious Diseases*
PART Rating	CY 2004: Adequate
Lead Agency	Centers for Disease Control and Prevention
PART Finding	The Infectious Diseases program has helped control infectious disease.
Key Follow-up Action	Make grantee performance data available to the public in a more transparent and meaningful way.
Action Taken	The Web site for Epi and Lab Capacity infectious disease cooperative agreement has been established and state content is currently under review by the Epi and Lab Capacity grantees.

HHS Strategic Goal: *1*	*Sexually Transmitted Diseases (STD) / Tuberculosis (TB)*
PART Rating	CY 2004: Adequate
Lead Agency	Centers for Disease Control and Prevention
PART Finding	Both the STD and TB activities have a clear purpose and address specific and ongoing problems.
Key Follow-up Action	The program will track performance on the new long-term and annual performance measures and will also develop a measure to track its efficiency.
Action Taken	The program routinely reports its performance information in CDC's performance budget submissions to HHS, OMB, and Congress.

HHS Strategic Goal: *1*	*Environmental Health*
PART Rating	CY 2005: Adequate
Lead Agency	Centers for Disease Control and Prevention
PART Finding	The program addresses the specific need to reduce and mitigate human exposure to a variety of toxic substances and hazardous environmental conditions.
Key Follow-up Action	Tie budget requests to the accomplishment of annual and long-term goals, and present resource needs in a complete and transparent manner.
Action Taken	Completed.

HHS Strategic Goal: *1*	*President's Emergency Plan For AIDS Relief: Focus Countries*[8]
PART Rating	CY 2005: Moderately Effective
Lead Agency	Centers for Disease Control and Prevention
PART Finding	The Emergency Plan demonstrated measurable progress towards long-term goals.
Key Follow-up Action	The Office of the Global AIDS coordinator will implement a system to capture expenditures by country.
Action Taken	Action taken, but not completed.

HHS Strategic Goal: *1*	*President's Emergency Plan For AIDS Relief: Other Bilateral Programs*[9]
PART Rating	CY 2005: Adequate
Lead Agency	Centers for Disease Control and Prevention

[8] HHS worked with the Department of State and the US Agency for International Development to complete the PART reviews for the President's Emergency Plan for AIDS Relief. These PARTs are listed on www.ExpectMore.Gov under the Department of State.
[9] Same as footnote above.

PART Finding	The strength of existing programs operated by CDC and USAID enabled the Emergency Plan to rapidly improve existing mechanisms, grant structures and relationships already established on the ground.
Key Follow-up Action	Providing an aggressive target for the program's long-term measure.
Action Taken	Action taken, but not completed.

HHS Strategic Goal: *1*	***Global Immunizations***
PART Rating	CY 2005: Effective
Lead Agency	Centers for Disease Control and Prevention
PART Finding	The program has a clear purpose: to eliminate or reduce vaccine-preventable diseases overseas.
Key Follow-up Action	Tie budget requests to the accomplishment of annual and long-term goals, and present resource needs in a complete and transparent manner.
Action Taken	Action taken, but not completed.

HHS Strategic Goal: *1*	***Health Statistics***
PART Rating	CY 2005: Moderately Effective
Lead Agency	Centers for Disease Control and Prevention
PART Finding	The program has established annual and long-term performance measures and is able to show progress in achieving its goals.
Key Follow-up Action	Tying budget requests to the accomplishment of annual and long-term goals, and present resource needs in a complete and transparent manner.
Action Taken	The program is participating in agency-wide efforts for budget and performance integration.

Substance Abuse and Mental Health Services Administration

HHS Strategic Goal: *1*	***Substance Abuse Treatment Programs of Regional and National Significance (PRNS)***
PART Rating	CY 2002: Adequate
Lead Agency	Substance Abuse and Mental Health Services Administration
PART Finding	The program had not regularly used performance information to improve outcomes, and has little data to indicate progress on performance measures.
Key Follow-up Action	Implementing an automated system for better and timelier data collection and reporting.
Action Taken	Completed. Program has implemented an automated data collection and reporting system. Data are being collected for all measures and used to manage the program.

HHS Strategic Goal: *1*	***Substance Abuse Prevention and Treatment Block Grant***
PART Rating	CY 2003: Ineffective
Lead Agency	Substance Abuse and Mental Health Services Administration
PART Finding	No independent evaluation of the program has been completed.
Key Follow-up Action	Conducting an independent and comprehensive evaluation of the national program.
Action Taken	Evaluability assessment completed. National evaluation is in progress.

HHS Strategic Goal: *1*	*Substance Abuse Prevention Programs of Regional and National Significance*
PART Rating	CY 2004: Moderately effective
Lead Agency	Substance Abuse and Mental Health Services Administration
PART Finding	Previous evaluations of program components suffered from inadequate data collection at the grantee level.
Key Follow-up Action	Developing an efficiency measure and baseline data
Action Taken	An efficiency measure was approved in December 2005 and baseline data have been reported.

Office of the Secretary

HHS Strategic Goal: *1*	*Office on Women's Health (OWH)*
PART Rating	CY 2004: Results Not Demonstrated
Lead Agency	Office of the Secretary/Office of Public Health and Science
PART Finding	The Office on Women's Health (OWH) demonstrated a strong health information dissemination role through the National Women's Health Information Center, an award winning website with customized women's health information. OWH seeks to identify gaps and influence changes in health care for women and girls.
Key Follow-up Action	Develop performance measures and an efficiency measure to track progress on promoting the healthier lives of women and girls.
Action Taken	Performance measures and an efficiency measure were developed.

HHS Strategic Goal: *1*	*Office of Disease Prevention and Health Promotion (ODPHP)*
PART Rating	CY 2005: Results Not Demonstrated
Lead Agency	Office of the Secretary/Office of Public Health and Science (OPHS)
PART Finding	ODPHP provides leadership, coordination, and policy development for public health prevention activities. The office needs to develop an accountability mechanism for addressing the achievement of the Nation's health objectives which it monitors.
Key Follow-up Action	ODPHP will develop a long-term performance measure tied to the Healthy People 2010 objectives for the Nation.
Action Taken	OPHS is working with ODPHP as well as two other staff offices PARTed in 2004 and 2005 to develop common long-term performance measures tied to the Healthy People 2010 objectives for the Nation.

Strategic Goal 2: Enhance the Ability of the Nation's Health Care System to Effectively Respond to Bioterrorism and Other Public Health Challenges

Centers for Disease Control and Prevention

HHS Strategic Goal: 2	*State and Local Preparedness*
PART Rating	CY 2003: Results Not Demonstrated
Lead Agency	Centers for Disease Control and Prevention
PART Finding	This effort is well coordinated with other Federal preparedness efforts including the Health Resources and Services Administration Hospital Preparedness grants. The programs have joint grant announcements and are cross referenced in cooperative agreements with grantees.
Key Follow-up Action	Will work with State and local representatives to ensure that performance information will be available to determine when acceptable preparedness has been demonstrated, and to target assistance for those areas that are not adequately prepared.
Action Taken	Initial set of performance measures have been collected and analyzed. Plans are being put into place, on a project by project basis, to assess potential barriers for data collection, reporting and performance for any performance measure not reported or not attained. Based on this assessment, technical assistance will be provided to the project.

HHS Strategic Goal: 2	*Strategic National Stockpile*
PART Rating	CY 2005: Moderately Effective
Lead Agency	Centers for Disease Control and Prevention
PART Finding	The Strategic National Stockpile has a focused and well-defined mission and is generally well managed, but improvement is needed in the process for identifying procurement priorities.
Key Follow-up Action	Tie budget requests to the accomplishment of annual and long-term goals, and present resource needs in a complete and transparent manner.
Action Taken	Action taken, but not completed.

Health Resources and Services Administration

HHS Strategic Goal: 2	*National Bioterrorism Hospital Preparedness*
PART Rating	CY 2003: Results Not Demonstrated
Lead Agency	Health Resources and Services Administration
PART Finding	The program's purpose and importance are clear, but program lacks data indicating its effectiveness, largely attributable to the fact that the program is relatively new.
Key Follow-up Action	Assess whether additional revisions of the funding formula are needed.
Action Taken	Funding formula was revised for FY 2005. Base award was decreased and the remainder was awarded based on population size.

Strategic Goal 3: Increase the Percentage of the Nation's Children and Adults Who Have Access to Health Care Services, and Expand Consumer Choices

Centers for Medicare & Medicaid Services

HHS Strategic Goal: 3	*State Children's Health Insurance Program*
PART Rating	CY 2003: Adequate
Lead Agency	Centers for Medicare & Medicaid Services
PART Finding	The program has been successful in enrolling and providing health coverage to uninsured children.
Key Follow-up Action	Work with states to develop long-term goals and implement a core set of national performance measures to evaluate quality of care received by low-income children.
Action Taken	CMS is developing a core set of performance measures through the Performance Measurement Partnership Project.

HHS Strategic Goal: 3	*Medicare*
PART Rating	CY 2003: Moderately Effective
Lead Agency	Centers for Medicare & Medicaid Services
PART Finding	Medicare has been successful in protecting the health of beneficiaries and is working to strengthen its management practices.
Key Follow-up Action	Timely implementation of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.
Action Taken	More than 38 million beneficiaries now have drug coverage.

Health Resources and Services Administration

HHS Strategic Goal: 3	*Health Centers Program*
PART Rating	CY 2002: Effective
Lead Agency	Health Resources and Services Administration
PART Finding	The program is designed to have a unique and significant impact and evaluations indicate the program is effective at extending high quality health care to underserved populations.
Key Follow-up Action	Complete the President's commitment to create 1,200 new or expanded health center sites by the end of 2007.
Action Taken	Budget to accomplish this was requested.

HHS Strategic Goal: 3	*Maternal and Child Health Block Grant (MCH)*
PART Rating	CY 2002: Moderately Effective
Lead Agency	Health Resources and Services Administration
PART Finding	The program is well designed and it regularly collects timely and credible performance data and is achieving results.
Key Follow-up Action	Conduct independent evaluation
Action Taken	Independent evaluation of the MCH Block Grant program completed and second evaluation underway.

HHS Strategic Goal: 3	*Ryan White CARE Act*
PART Rating	CY 2002: Adequate
Lead Agency	Health Resources and Services Administration
PART Finding	The program has had a positive impact, its purpose is clear, and there is effective coordination with similar programs.
Key Follow-up Action	Implement preemptive mechanisms to identify problems or make corrective fixes prior to the mismanagement of resources by grantees or sub-grantees
Action Taken	Mechanisms put in place to assure grantees use funds appropriately including improved grantee monitoring, additional technical assistance resources, and enhanced compliance activities.

HHS Strategic Goal: 3	*National Health Service Corps*
PART Rating	CY 2002: Moderately Effective
Lead Agency	Health Resources and Services Administration
PART Finding	The program purpose is clear, it is designed to have a unique and significant impact, and it uses performance information to improve outcomes.
Key Follow-up Action	Improve efficiency through greater flexibility in the allocation of funds between scholarships and loans.
Action Taken	Program allocates a larger proportion of funds to loan category.

HHS Strategic Goal: 3	*Nurse Education Loan Repayment Program*
PART Rating	CY 2002: Adequate
Lead Agency	Health Resources and Services Administration
PART Finding	The program is the only Federal program designed to provide financial incentives directly to registered nurses to send them into shortage facilities as a means of improving access to care.
Key Follow-up Action	Conduct independent evaluation.
Action Taken	An evaluation has been completed.

HHS Strategic Goal: 3	*Health Professions*
PART Rating	CY 2002: Ineffective
Lead Agency	Health Resources and Services Administration
PART Finding	While the program is managed well overall, it has not regularly used performance data to improve program outcomes.
Key Follow-up Action	Increase activities to promote basic nursing.
Action Taken	Program components (e.g., career ladder component) have been added to focus activities on basic nursing.

HHS Strategic Goal: 3	*Rural Health Activities*
PART Rating	CY 2003: Adequate
Lead Agency	Health Resources and Services Administration
PART Finding	The purpose of the Rural Health portfolio is clear, but is duplicative of other programs in HHS.
Key Follow-up Action	Make performance data available to the public in a transparent and meaningful manner.
Action Taken	Performance information is made available in a number of ways, including posting goals, performance measures, and data on the program's website.

HHS Strategic Goal: 3	*Children's Hospitals Graduate Medical Education Payment Program*
PART Rating	CY 2003: Adequate
Lead Agency	Health Resources and Services Administration
PART Finding	The program purpose is clear and it meets goal of processing payments on time, but is duplicative of other programs.
Key Follow-up Action	Examine whether program can improve efficiency by paying hospitals on a quarterly basis.
Action Taken	Analysis of whether efficiencies can be gained by making quarterly payments has been done.

HHS Strategic Goal: 3	*Organ Transplantation Program*
PART Rating	CY 2004: Adequate
Lead Agency	Health Resources and Services Administration
PART Finding	Program has clear purpose and addresses an existing need, and it collects extensive performance information to manage the grantees' performance.
Key Follow-up Action	Work with organ procurement organizations, transplant centers, and others to increase the number of deceased transplant donors and the number of organs transplanted from each donor.
Action Taken	Program has expanded the Organ Donation Breakthrough Collaborative and has completed a study, via contract, on effective practices to increase the number of transplantable organs from each deceased donor.

HHS Strategic Goal: 3	*National Bone Marrow Donor Registry*
PART Rating	CY 2004: Moderately Effective
Lead Agency	Health Resources and Services Administration
PART Finding	The program has a clear purpose, serves a specific need and has demonstrated effectiveness.
Key Follow-up Action	Work on a methodology for determining one-year patient survival rates and establish baseline and target for this performance measure.
Action Taken	Program has developed such a methodology and has established a baseline and target for this long-term measure.

HHS Strategic Goal: 3	*Poison Control*
PART Rating	CY 2004: Adequate
Lead Agency	Health Resources and Services Administration
PART Finding	The program has a clear purpose and has demonstrated progress toward achieving its long-term goal, and has made progress toward stabilizing Poison Control Centers.
Key Follow-up Action	Collect timely and credible performance information from key program partners.
Action Taken	New grantee performance measures have been developed and approved and grantees have begun to report on these new measures.

HHS Strategic Goal: 3	*Traumatic Brain Injury*
PART Rating	CY 2004: Results Not Demonstrated
Lead Agency	Health Resources and Services Administration
PART Finding	Program has clear purpose and addresses an existing need, but does not have data showing a health impact.
Key Follow-up Action	Acquire evidence of program impact.
Action Taken	An evaluation of the program has been conducted by the Institute of Medicine and a health outcome performance measure has been developed.

HHS Strategic Goal: 3	*Emergency Medical Services for Children*
PART Rating	CY 2004: Results Not Demonstrated
Lead Agency	Health Resources and Services Administration
PART Finding	The program has a clear purpose, addresses existing need, but does not have data demonstrating a health impact.
Key Follow-up Action	Acquire evidence of program impact.
Action Taken	An evaluation of the program has been conducted by the Institute of Medicine and a health outcome performance measure has been developed.

HHS Strategic Goal: 3	*Health Facilities Construction and Other Miscellaneous Congressional Earmarks*
PART Rating	CY 2005: Results Not Demonstrated
Lead Agency	Health Resources and Services Administration
PART Finding	Earmarks projects often serve local interests and do not fulfill national priorities or needs.
Key Follow-up Action	
Action Taken	No funds were appropriated for this program for FY 2006.

HHS Strategic Goal: 3	*Healthy Community Access Program*
PART Rating	CY 2005: Ineffective
Lead Agency	Health Resources and Services Administration
PART Finding	It is unclear that all federal funds expand access to health care and program is duplicative of other efforts.
Key Follow-up Action	Propose elimination of program.
Action Taken	No funds were appropriated for this program for FY 2006.

HHS Strategic Goal: 3	*State Planning Grant Program*
PART Rating	CY 2005: Ineffective
Lead Agency	Health Resources and Services Administration
PART Finding	There is no clear need for this program and program is duplicative of other efforts.
Key Follow-up Action	Propose elimination of program.
Action Taken	No funds were appropriated for this program for FY 2006.

HHS Strategic Goal: 3	*Trauma-EMS Systems Program*
PART Rating	CY 2005: Adequate
Lead Agency	Health Resources and Services Administration
PART Finding	The program has demonstrated success in assisting States in adopting statewide standardized triage protocols and designating trauma centers.
Key Follow-up Action	Establish targets for annual measures.
Action Taken	Targets established. No funds were appropriated for this program for FY 2006.

HHS Strategic Goal: 3	*Universal Newborn Hearing Screening Program*
PART Rating	CY 2005: Moderately Effective
Lead Agency	Health Resources and Services Administration
PART Finding	The program has made great progress in achieving its primary goal of screening for hearing loss and is working toward a new goal related to improved health outcomes.
Key Follow-up Action	Complete independent evaluation of program.
Action Taken	Evaluation completed.

HHS Strategic Goal: 3	*Vaccine Injury Compensation Program*[10]
PART Rating	CY 2005: Adequate
Lead Agency	Health Resources and Services Administration
PART Finding	The program has made progress in achieving its annual performance goals, but its performance on long-term goals has been inconsistent.
Key Follow-up Action	Conduct independent evaluation of program.
Action Taken	Contracted a study, which is underway, to assess the feasibility and parameters of a program evaluation.

HHS Strategic Goal: 3	*Family Planning*
PART Rating	CY 2005 : Moderately Effective
Lead Agency	Health Resources and Services Administration (managed by Office of the Secretary/Office of Public Health and Science)
PART Finding	The Program's overall purpose, design and management are strong.
Key Follow-up Action	Develop performance goals for all key program activities.
Action Taken	Baseline and performance targets have been established for all key program activities.

Indian Health Service

HHS Strategic Goal: 3	*Federally Administered Activities*
PART Rating	CY 2002: Moderately Effective
Lead Agency	Indian Health Service
PART Finding	The program has developed new performance measures to assess progress in reducing morbidity and mortality related to those health issues most prevalent today.
Key Follow-up Action	Ensuring that performance goals factor in past performance and encourage continued improvement each year.
Action Taken	Action taken, but not completed.

[10] HHS worked with the Department of Justice to complete the PART review for the Vaccine Injury Compensation program. This PART is listed on www.ExpectMore.Gov under the Department of Justice.

HHS Strategic Goal: 3	*Sanitation Facilities Construction Program*
PART Rating	CY 2002: Moderately Effective
Lead Agency	Indian Health Service
PART Finding	A recent program evaluation found that the program is effectively designed and managed.
Key Follow-up Action	Implementing a strategic planning process, as recommended by the independent evaluation.
Action Taken	Action taken, but not completed.

HHS Strategic Goal: 3	*Urban Indian Health Program*
PART Rating	CY 2003: Adequate
Lead Agency	Indian Health Service
PART Finding	The program is duplicative of other publicly-funded programs.
Key Follow-up Action	Redirecting funding from this program to other activities conducted by the Indian Health Service.
Action Taken	The FY 2007 budget requests that funding for this program be redirected to other activities within the Indian Health Service.

HHS Strategic Goal: 3	*Resource and Patient Management System*
PART Rating	CY 2003: Effective
Lead Agency	Indian Health Service
PART Finding	The program has a clear purpose to provide accurate, timely, and comprehensive information to Indian Health Service providers and program managers.
Key Follow-up Action	Developing Resource and Patient Management System's capability to provide a valid cost accounting link to health outcomes.
Action Taken	Action taken, but not completed.

HHS Strategic Goal: 3	*Health Care Facilities Construction Program*
PART Rating	CY 2004: Effective
Lead Agency	Indian Health Service
PART Finding	The program is developing facility-specific annual performance measures.
Key Follow-up Action	Ensuring that performance goals factor in past performance and encourage continued improvement each year.
Action Taken	Action taken, but not completed. Annual performance measures are being developed.

HHS Strategic Goal: 3	*Tribally Operated Health Programs*
PART Rating	CY 2005: Adequate
Lead Agency	Indian Health Service
PART Finding	Performance information for annual indicators is only available for programs that voluntarily report data, or 85 percent of patients served in 2005.
Key Follow-up Action	Negotiating with tribal programs to include in contracts and compacts the submission of clinical performance data to achieve a reporting rate of at least 90 percent of the population served by 2008.
Action Taken	Action taken but not completed. Tribes are being encouraged to submit performance data, whether voluntary or through a negotiated contract requirement. The goal is 100 percent reporting.

Substance Abuse and Mental Health Services Administration

HHS Strategic Goal: 3	*Children's Mental Health Services*
PART Rating	CY 2002: Moderately effective
Lead Agency	Substance Abuse and Mental Health Services Administration
PART Finding	The program is reporting on outcomes.
Key Follow-up Action	Developing an efficiency measure.
Action Taken	The program has been reporting on and achieving reductions in inpatient care costs. The program combined its two cost measures into a single approved efficiency measure, "Decrease in inpatient care costs per 1,000 children served."

HHS Strategic Goal: 3	*Project for Assistance in Transition from Homelessness (PATH)*
PART Rating	CY 2002: Moderately effective
Lead Agency	Substance Abuse and Mental Health Services Administration
PART Finding	The program can take additional steps to improve administrative efficiency.
Key Follow-up Action	Tracking and improving program performance using newly developed long-term outcome and efficiency measures
Action Taken	Measures are in place and data are being collected.

HHS Strategic Goal: 3	*Community Mental Health Services Block Grant*
PART Rating	CY 2003: Adequate
Lead Agency	Substance Abuse and Mental Health Services Administration
PART Finding	No comprehensive evaluations have been completed to date on the program.
Key Follow-up Action	Conducting an evaluation of the program.
Action Taken	An evaluability assessment was completed. The national evaluation is in progress.

HHS Strategic Goal: 3	*Mental Health Programs of Regional and National Significance*
PART Rating	CY 2005: Results Not Demonstrated
Lead Agency	Substance Abuse and Mental Health Services Administration
PART Finding	Mental Health Projects of Regional and National Significance need to further develop performance measures.
Key Follow-up Action	Implementing automated web-based performance system including development and implementation of common performance measures on which all grantees must report.
Action Taken	Common measures for programs that provide mental health treatment services have been developed and a Federal Register Notice to begin the OMB clearance process was published on June 9, 2006. System is expected to be fully implemented in 2007

HHS Strategic Goal: 3	*Protection and Advocacy for Individuals with Mental Illness (PAIMI)*
PART Rating	CY 2005: Moderately Effective
Lead Agency	Substance Abuse and Mental Health Services Administration
PART Finding	The program is collecting data that demonstrates improved outcomes.
Key Follow-up Action	Providing grantees with guidelines as to how to calculate the number of PAIMI-eligible individuals impacted, including a definition of "impacted," so that reporting on efficiency measures across States will be more consistent in the future.
Action Taken	Completed. Guidance was developed by the PAIMI work group and sent to all grantees in April 2006. This guidance included the definition of 'impacted' and a set of criteria to determine if PAIMI interventions are successful or unsuccessful.

Office of the Secretary

HHS Strategic Goal: 3	*Office for Civil Rights*
PART Rating	CY 2005: Moderately Effective
Lead Agency	Office of the Secretary/Office for Civil Rights
PART Finding	The program has been identified as having a strong purpose and design.
Key Follow-up Action	Ensure that partnership agreements with other HHS offices long with Federal agencies outside of HHS include provisions that address the attainment of annual and long-term measures.
Action Taken	OCR now mandates inclusion of its PART goals and measures in all of its partnership agreements.

HHS Strategic Goal: 3	*Office of Minority Health (OMH)*
PART Rating	CY 2005: Results Not Demonstrated
Lead Agency	Office of the Secretary/Office of Public Health and Science
PART Finding	While the Office of Minority Health (OMH) has developed initiatives to test interventions for reducing racial/ethnic disparities in areas such as heart disease, stroke, and cancer, measures to demonstrate the impact of its programs on improving the health of minorities need to be developed.
Key Follow-up Action	Develop a draft strategic framework & logic model with preliminary long- and short-term performance goals that are clearly linked to each other, reflect OMH's overall mission, and enable measurement of progress.
Action Taken	Action taken, but not completed. A draft strategic framework using a logic model approach is under development. The framework includes intended short-term impacts and long-term outcomes reflective of OMH's mission and will inform development of specific performance indicators/measures for OMH and its grantees, contractors, and other partners.

Strategic Goal 4: Enhance the Capacity and Productivity of the Nation's Health Science Research Enterprise

National Institutes of Health

HHS Strategic Goal: 4	*HIV/AIDS Research Program*
PART Rating	CY 2003: Moderately Effective
Lead Agency	National Institutes of Health
PART Finding	The program has a flexible and cross-cutting design that explicitly allows the Office of AIDS Research to plan, identify, evaluate, and fund AIDS research priorities across the Institutes.
Key Follow-up Action	Evaluate the efficacy of 3 new HIV treatment strategies in clinical trials to identify agents/combinations of agents that are more effective, less toxic, and/or simpler to use than current regimens.
Action Taken	Action Taken, not completed.

HHS Strategic Goal: 4	*Extramural Research Program*
PART Rating	CY 2004: Effective
Lead Agency	National Institutes of Health
PART Finding	The program is the only governmental or private program that has a broad mission of improving the Nation's health through funding biomedical and behavioral research.
Key Follow-up Action	Identify and characterize molecular events that may prove to be targets for treating or preventing Alzheimer's disease through initiatives and projects focused on mechanistic and basic studies.
Action Taken	Action Taken, not completed

HHS Strategic Goal: 4	*Intramural Research Program*
PART Rating	CY 2005: Effective
Lead Agency	National Institutes of Health
PART Finding	The program relies on a system of regular outside scientific reviews, and the funding scientists receive is adjusted based on the findings.
Key Follow-up Action	Enhance electronic sharing of 'omics (i.e., the study of a system of biomolecules, e.g., proteomics) and biology endpoint data to reduce overlap, identify gaps, and confirm/validate findings.
Action Taken	Action Taken, not completed

HHS Strategic Goal: 4	*Building and Facilities Program*
PART Rating	CY 2005: Effective
Lead Agency	National Institutes of Health
PART Finding	The program has a clear purpose and program design that is directed toward the specific needs of research activities, such as on-campus labs, equipment, animal holding facilities, and administrative space.
Key Follow-up Action	Ensure that approved design and construction projects are executed on time, on scope, and on budget by implementing and monitoring an earned value analysis and management system.
Action Taken	Action Taken, not completed

Strategic Goal 5: Improve the Quality of Health Care Services

Agency for Healthcare Research and Quality

HHS Strategic Goal: 5	*Data Collection and Dissemination*
PART Rating	CY 2002: Moderately Effective
Lead Agency	Agency for Healthcare Research and Quality
PART Finding	Collect performance data on the new measures.
Key Follow-up Action	Update annual targets and establish baselines where appropriate.
Action Taken	Completed

HHS Strategic Goal: 5	*Health Care Patient Safety*
PART Rating	CY 2003: Adequate
Lead Agency	Agency for Healthcare Research and Quality
PART Finding	Monitor the Agency for Healthcare Research and Quality's progress toward developing baselines for newly developed long-term and annual performance goals.
Key Follow-up Action	Analyze data from Patient Safety hospital survey and establish baseline for the percent of hospitals reporting on adverse events as standard practice.
Action Taken	Data analysis of survey is currently being conducted.

HHS Strategic Goal: 5	*Pharmaceutical Outcomes*
PART Rating	CY 2004: Moderately Effective
Lead Agency	Agency for Healthcare Research and Quality
PART Finding	Update baselines and targets for annual performance measures that continue to be developed and realized.
Key Follow-up Action	Analyze FY 2006 data and update annual targets.
Action Taken	Analysis of FY 2006 data is currently being conducted.

Food and Drug Administration

HHS Strategic Goal: 5	*Food and Drug Administration (FDA)*
PART Rating	CY 2003: Moderately Effective
Lead Agency	Food and Drug Administration
PART Finding	FDA is well managed, and has a strong and comprehensive strategic planning process.
Key Follow-up Action	Develop an efficiency measure.
Action Taken	Completed

Office of the Secretary

HHS Strategic Goal: 5	*Afghanistan Health Initiative*
PART Rating	CY 2005: Results Not Demonstrated
Lead Agency	Office of Global Health Affairs
PART Finding	The program has developed both long-term and annual measures reflective of the program's purpose.
Key Follow-up Action	Establish baselines and ambitious targets for its annual performance goals.
Action Taken	Continue to analyze the performance of the Afghanistan Health Initiative.

HHS Strategic Goal: 5	*US Mexico Border Health Commission*
PART Rating	CY 2005: Results Not Demonstrated
Lead Agency	Office of Global Health Affairs
PART Finding	The program has established performance goals and targets, but is still collecting performance results.
Key Follow-up Action	Develop an efficiency measure; collect and report performance data.
Action Taken	Developed an efficiency measure and collecting data to show progress in performance of the program.

Strategic Goal 6: Improve the Economic and Social Well-being of Individuals, Families, and Communities, Especially Those Most in Need

Administration for Children and Families

HHS Strategic Goal: 6	*Refugee and Entrant Assistance (Social Services and Targeted Assistance)*
PART Rating	CY 2002: Adequate
Lead Agency	Administration for Children and Families
PART Finding	The program has lacked regular independent evaluations.
Key Follow-up Action	Conducting an independent and quality evaluation that will analyze outcomes related to employment and self-sufficiency in three program sites.
Action Taken	A program evaluation is underway and is expected to finish in 2007.

HHS Strategic Goal: 6	*Low Income Home Energy Assistance Program*
PART Rating	CY 2003: Results Not Demonstrated
Lead Agency	Administration for Children and Families
PART Finding	As a block grant that provides maximum flexibility to states, the program faces challenges in developing performance measures.
Key Follow-up Action	Working to develop performance measures.
Action Taken	The program has developed an efficiency measure to capture the number of households assisted per $100 of administrative costs.

HHS Strategic Goal: 6	*Community Services Block Grant*
PART Rating	CY 2003: Results Not Demonstrated
Lead Agency	Administration for Children and Families
PART Finding	The program lacks measures to demonstrate that it is achieving results.
Key Follow-up Action	Developing more meaningful national performance measures and targets, as well as a program efficiency measure.
Action Taken	The program has developed an efficiency measure to capture administrative expenditures per person served.

HHS Strategic Goal: 6	*Developmental Disabilities Grant Programs*
PART Rating	CY 2003: Adequate
Lead Agency	Administration for Children and Families
PART Finding	While the program has performance measures, it lacks an efficiency measure to assess its cost-effectiveness and independent evaluations to assess its impact.
Key Follow-up Action	Developing an efficiency measure to demonstrate how well the program is performing.
Action Taken	The program has developed an efficiency measure to capture the number of individuals with developmental disabilities reached who are independent, self-sufficient, and integrated into the community per $1,000 of Federal funding.

HHS Strategic Goal: 6	*Assets for Independence*
PART Rating	CY 2004: Adequate
Lead Agency	Administration for Children and Families
PART Finding	The program addresses the specific problem of asset poverty. Research indicates that a quarter of American households are "asset poor," meaning families have insufficient financial resources to support them at the poverty level for three months (during a suspension of income).
Key Follow-up Action	Developing grantee-supported performance outcome measures and targets that demonstrate improved efficiencies or cost effectiveness.
Action Taken	The program has developed a set of outcome and efficiency measures.

HHS Strategic Goal: 6	*Family Violence Prevention and Services Program*
PART Rating	CY 2004: Results Not Demonstrated
Lead Agency	Administration for Children and Families
PART Finding	The program addresses a specific problem. It is estimated that the shelters house more than 300,000 women and children during a program year; and the hotline receives an average of 13,000 calls each month.
Key Follow-up Action	Working to develop appropriate national grantee-supported performance outcome measures to demonstrate improved efficiencies or cost effectiveness.
Action Taken	The Family Violence Prevention and Services Program has been working extensively with partners to develop meaningful outcome performance measures.

HHS Strategic Goal: 6	*Refugee and Entrant Assistance (Transitional and Medical Services)*
PART Rating	CY 2005: Effective
Lead Agency	Administration for Children and Families
PART Finding	The program is focused on achieving meaningful performance outcome goals.
Key Follow-up Action	Working with grantees and states to improve data collection and monitoring through electronic data submissions.
Action Taken	The program is working with grantees and states to improve data collection and monitoring through electronic data submissions.

HHS Strategic Goal: *6*	*Social Services Block Grant*
PART Rating	CY 2005: Results Not Demonstrated
Lead Agency	Administration for Children and Families
PART Finding	This program provides maximum flexibility to states to direct their Federal grant to purposes and activities most tailored to states' needs and imposes minimal reporting burdens.
Key Follow-up Action	Consulting with states on approaches to developing long-term and annual performance measures.
Action Taken	Action taken, but not completed.

HHS Strategic Goal: *6*	*Temporary Assistance for Needy Families (TANF)*
PART Rating	CY2005: Moderately Effective
Lead Agency	Administration for Children and Families
PART Finding	The program has produced modest, but statistically significant increases in employment and earnings among welfare recipients as well as reduced caseloads, poverty, and welfare dependency.
Key Follow-up Action	Reassessing the program's performance measures and related targets.
Action Taken	Making preliminary reassessment based on the estimated gap between States' current work participation rates and projected target rates States need to achieve for FY 2007.

Administration on Aging

HHS Strategic Goal: *6*	*Aging Services Program*
PART Rating	CY 2003: Moderately Effective
Lead Agency	Administration on Aging
PART Finding	The program has a clear purpose and is well managed.
Key Follow-up Action	Completing evaluations on disease prevention and health promotion, supportive services, nutrition programs and the National Family Caregivers Support program.
Action Taken	The evaluation of disease prevention and health promotion is completed; the final report has been approved and is available on the AoA Web site. The evaluation of supportive services is underway and should be completed this year. The nutrition evaluation will be funded soon, and the evaluation of the National Family Caregivers Support program is in the planning stages.

HHS Strategic Goal: 6	*Adolescent Family Life Program (AFL)*
PART Rating	CY 2004 : Results Not Demonstrated
Lead Agency	Office of the Secretary/Office of Public Health and Science
PART Finding	The Adolescent Family Life Program supports the evaluation activities of each funded demonstration project individually. Agency wide performance and efficiency measures need to be in place to effectively monitor program improvements.
Key Follow-up Action	AFL will develop performance measures and an efficiency measure. Core data instruments will be developed for grantee use in 2006 and will directly relate to AFL measures.
Action Taken	Developed performance measures and an efficiency measure. Core data instruments were developed and all grantees funded after FY 2004 are required to incorporate the core data instruments into their evaluation designs.

Strategic Goal 7: Improve Stability and Healthy Development of Our Nation's Children and Youth

Administration for Children and Families

HHS Strategic Goal: 7	*Head Start*
PART Rating	CY 2002: Results Not Demonstrated
Lead Agency	Administration for Children and Families
PART Finding	Though the Head Start program has an overall reputation for providing high quality, comprehensive services to young, low-income children, there is no system in place for assessing the progress of individual Head Start program grantees in preparing children for school.
Key Follow-up Action	Implementing and operating a National Reporting System to assess every 4-year-old in Head Start in the fall and spring of their pre-school year.
Action Taken	The Office of Head Start has implemented the National Reporting System to assess all 4-year-olds in the fall and spring of their pre-school year.

HHS Strategic Goal: 7	*Foster Care*
PART Rating	CY 2003: Adequate
Lead Agency	Administration for Children and Families
PART Finding	Foster Care was found to be managed effectively. The program uses the Child and Family Services Reviews to devise new management strategies and direct technical assistance resources. Also, financial management practices for the foster care maintenance payments program include eligibility reviews, state and Inspector General audits, and regional office assessment and resolution of state claims.
Key Follow-up Action	Developing legislation to introduce an option to states to participate in an alternative financing system for child welfare that will better meet the needs of each state's foster care population.
Action Taken	Action taken, but not completed. The deadline for drafting legislation was met. ACF continues to work with Congress to introduce the Bill.

HHS Strategic Goal: 7	*Child Support Enforcement*
PART Rating	CY2003: Effective
Lead Agency	Administration for Children and Families
PART Finding	The program relies on its clear purpose and unambiguous mission linked to salient and meaningful performance measures.
Key Follow-up Action	Developing two new indicators to measure the extent to which medical support is not only ordered but also provided in child support cases.
Action Taken	Action taken but not completed. States will submit medical support performance measures for FY 2006.

HHS Strategic Goal: 7	*Runaway and Homeless Youth*
PART Rating	CY 2003: Results Not Demonstrated
Lead Agency	Administration for Children and Families
PART Finding	The program cannot demonstrate its ability to care for runaway and homeless youth, because it lacks appropriate performance measures, missed targets for existing measures, and does not conduct evaluations on a regular basis.
Key Follow-up Action	Developing appropriate outcome and efficiency measures, and documenting progress on attaining targets.
Action Taken	The program has developed performance measures.

HHS Strategic Goal: 7	*CAPTA State Grants*
PART Rating	CY 2004: Results Not Demonstrated
Lead Agency	Administration for Children and Families
PART Finding	The program was found not to have focused sufficient attention on increasing the efficiency of protective services.
Key Follow-up Action	Implementing a newly developed efficiency measure for decreased response time to reported cases of child abuse and neglect.
Action Taken	The new performance measure is included in ACF's FY 2007 performance budget.

HHS Strategic Goal: 7	*Community-Based Child Abuse Prevention*
PART Rating	CY 2004: Results Not Demonstrated
Lead Agency	Administration for Children and Families
PART Finding	The program was found not to have an efficiency measure in place.
Key Follow-up Action	Working to develop and implement an efficiency measure.
Action Taken	The program has developed an efficiency measure to track grantees' use of evidence-based practices/programs.

HHS Strategic Goal: 7	*Independent Living Program*
PART Rating	CY 2004: Results Not Demonstrated
Lead Agency	Administration for Children and Families
PART Finding	The program lacks appropriate performance goals, including an efficiency measure to determine the program's effectiveness.
Key Follow-up Action	Developing ambitious performance measures and targets using the new National Youth in Transition Database, including employment and homelessness rates of youth served by the program who have aged out of the foster care system.
Action Taken	Action taken but not completed. The program has developed an interim, efficiency measure and data will be reported in October 2006. The NPRM for the National Youth in Transition Database (NYTD) was published in the Federal Register in July 2006. Additional performance measures will be developed once NYTD is fully implemented.

HHS Strategic Goal: 7	*Child Care and Development Fund*
PART Rating	CY 2004: Moderately Effective
Lead Agency	Administration for Children and Families
PART Finding	The program has strong oversight practices in place, including disallowing inappropriately-claimed costs, delaying approval of state plans until requirements are met, and investigating public complaints. State grantees also take action to hold subgrantees and state contractors accountable. However, the program lacks in-depth, on-site monitoring of grantee activities.
Key Follow-up Action	Initiating a series of activities to measure erroneous payments and improve grantee oversight.
Action Taken	Activities to measure erroneous payments are underway.

HHS Strategic Goal: 7	*Adoption Opportunities*
PART Rating	CY 2005: Adequate
Lead Agency	Administration for Children and Families
PART Finding	The program awards competitive grants to develop and test innovative approaches to removing barriers to adoption.
Key Follow-up Action	Developing an appropriate efficiency measure, and refining current measures to develop more ambitious adoption targets and address existing data collection challenges.
Action Taken	The program has developed an efficiency measure to track the cost per adoptive placement for the Adoption Opportunities Program

HHS Strategic Goal: 7	*Adoption Assistance*
PART Rating	CY 2005: Moderately Effective
Lead Agency	Administration for Children and Families
PART Finding	The program increases permanent placement of foster care children, leading to both improved child well-being and reduced federal and state spending. The program focuses on harder-to-adopt children who are more likely to spend longer periods in foster care. By supporting permanent placements, the program also reduces the higher administrative costs associated with foster care.
Key Follow-up Action	Identifying barriers to increasing the proportion of foster care children receiving adoption assistance.
Action Taken	Action taken, but not completed. The program continues to make progress on this goal including launching a new series of public service advertisements in June 2006 designed to encourage the adoption of older children and teens from foster care.

HHS Strategic Goal: 7	*Adoption Incentives*
PART Rating	CY 2005: Adequate
Lead Agency	Administration for Children and Families
PART Finding	The program is generally well administered in providing financial incentives to states to increase the number of adoptions. States used the incentives appropriately to fund activities related to recruiting potential adoptive parents, providing staff training on adoption related issues, and providing post-adoption services.
Key Follow-up Action	Developing an efficiency measure which ties more closely to the program's goals.
Action Taken	Completed. The program has developed an efficiency measure to track the average administrative claim per IV-E Adoption Assistance child.

HHS Strategic Goal: 7	*Mentoring Children of Prisoners*
PART Rating	CY 2005: Results Not Demonstrated
Lead Agency	Administration for Children and Families
PART Finding	The program has yet to achieve its ambitious goal of establishing 100,000 matches of mentors with children in four years. The challenge of recruiting and training volunteer mentors and sustaining quality relationships was greater than anticipated.
Key Follow-up Action	Recalibrating targets and timeframes to reflect feasible levels of mentoring matches that can be achieved and estimate achievement of the 100,000 matches during FY 2008. Establishing a national training and technical assistance program.
Action Taken	Targets and timeframes have been recalibrated to reflect feasible levels of mentoring matches that can be achieved and estimate achievement of the 100,000 matches during FY 2008.

HHS Strategic Goal: 7	*Human Trafficking*
PART Rating	CY 2005: Moderately Effective
Lead Agency	Administration for Children and Families
PART Finding	The Human Trafficking program is well-managed and focused on achieving results. In response to difficulties in early implementation, the program has taken major steps to improve its design, management, and performance. Major changes in the program design were made to meet the statutory goals when the initial assumptions about how to identify victims were found to be incorrect, and the program has taken important steps to improve its planning and monitoring.
Key Follow-up Action	Improving strategic planning by systematically collecting information from practitioners about best practices for identifying victims of trafficking. Improving procedures for allocation of funds to organizations and implementing new systems to more effectively shepherd and track identified victims through the certification process.
Action Taken	Action taken, but not completed. Ongoing

Strategic Goal 8: Achieve Excellence in Management Practices

Centers for Disease Control and Prevention

HHS Strategic Goal: 8	*Buildings and Facilities*
PART Rating	CY 2004: Adequate
Lead Agency	Centers for Disease Control and Prevention (CDC)
PART Finding	The program uses a master plan of CDC headquarters construction projects to target resources.
Key Follow-up Action	CDC's Buildings and Facilities program will refine the newly adopted long-term measure and develop ambitious targets and timeframes.
Action Taken	CDC has been working with HHS to establish and verify the basis for a long-term performance measure. Phases I and II have been completed. CDC and HHS are currently working on the development of a final model and to determine its potential use as a metric.

Centers for Medicare & Medicaid Services

HHS Strategic Goal: 8	*Medicare Integrity Program*
PART Rating	CY 2002: Effective
Lead Agency	Centers for Medicare & Medicaid Services
PART Finding	The program relies on performance measures, such as the Medicare error rate, that are directly relevant to its purpose.
Key Follow-up Action	Develop contractor specific error rates and require contractors to commit to reducing their error rates.
Action Taken	Completed

Office of Inspector General

HHS Strategic Goal: *8*	***Health Care Fraud and Abuse Program (HCFAC)***
PART Rating	CY 2002: Results Not Demonstrated
Lead Agency	Office of Inspector General
PART Finding	The program does not have specific, ambitious long-term performance goals that focus on outcomes and meaningfully reflect the program's purpose.
Key Follow-up Action	The program should develop performance measures that are closely tied to the program's mission; measurable against an established objective baseline; and that can be used to make resource allocation decisions.
Action Taken	Completed