

## **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 acellular 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
<b>Data Source:</b> 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				
	2002	2003	2004	2005	2006
<b>Performance Measure</b>					
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
<b>Data Source:</b> 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
<b>Data Source:</b> 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				
	2002	2003	2004	2005	2006
Performance Goal					
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://www.dasis.samhsa.gov/dasis2/manuals/teds\\_adm\\_manual.pdf](http://www.dasis.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](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.