HHS ANNUAL PLAN

FY 2008

200 Independence Avenue S.W., Washington, D.C. 20201
www.hhs.gov
This document also available at www.hhs.gov/budget/docbudget.htm

HHS MISSION

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

HHS STRATEGIC GOALS

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

The Strategic Plan contains the following Strategic Goals:

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

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

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

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

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

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

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

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

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OVERVIEW

The United States Department of Health and Human Services (HHS) is the United States Government's principal agency for protecting the public's health and providing essential human services. The Department administers over 300 programs, which cover a wide spectrum of activities that affect the lives of all Americans. The Department's programs are administered by 11 Operating Divisions, including eight agencies in the United States Public Health Service and three human services agencies. Many HHS programs are implemented in coordination with State, local, Tribal and non-government partners, reflecting the combined leadership and commitment of HHS and its partners.

The Government Performance and Results Act (GPRA) provides the statutory framework for performance planning and requires the development of a five-year Strategic Plan, Annual Plan, Performance and Accountability Report (PAR), and program performance goals. The current HHS Strategic Plan covers FY 2004 – FY 2009 and includes eight strategic goals that link to the accomplishment of the Department's mission. HHS is currently updating the Strategic Plan for FY 2007 – FY 2012. The plan is scheduled for release later in FY 2007.

Through the HHS Annual Plan, the Department illustrates the far-reaching and positive effects of HHS programs. HHS Operating and Staff Divisions track and report over 700 performance measures in their Congressional Justifications. Given this large number, the FY 2008 HHS Annual Plan highlights only major HHS programs and corresponding performance measures that directly support the HHS Strategic Plan instead of listing all 700. The FY 2008 HHS Annual Plan includes an overview section, with an analysis of Program Assessment Rating Tool (PART) reviews, a summary of the President's Management Agenda (PMA), and charts presenting the FY 2008 budget by strategic goal. The program narrative section, organized by HHS strategic goal, describes how selected performance measures support achievement of the HHS strategic goals and objectives. For more detailed information on all of HHS programs and performance goals, please see www.hhs.gov/budget/.

HHS uses the annual budget process, strategic planning, and annual performance planning to guide the Department's policy and program priorities. The HHS annual performance budgets (i.e., the Congressional Justifications) present the resource needs of HHS programs and identify the results Americans can expect from their investment in these programs. The performance budgets state planned goals and also report on past achievements of all HHS programs. At the end of each fiscal year, HHS produces the PAR, which incorporates performance results and the audited financial statements for the year. Together, the Annual Plan, the performance budgets, and the PAR comprise an annual planning and reporting process for HHS programs.

Evaluation and Assessment

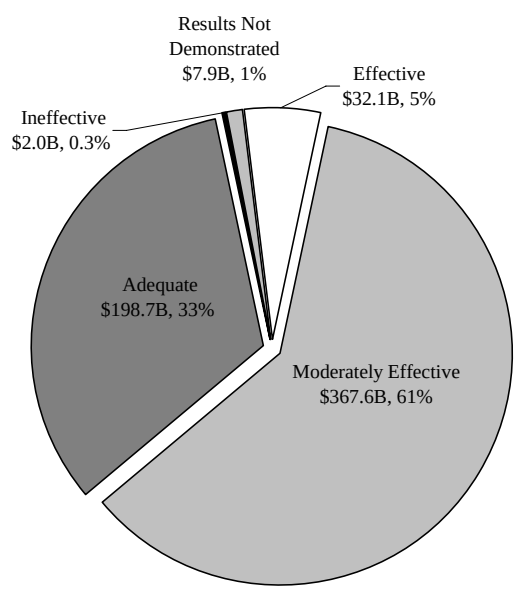
HHS' evaluation activities provide important information about HHS programs, and support and supplement the Department's ability to assess program performance. Each year, HHS conducts program evaluations to review program effectiveness, improve program management, develop performance measures, and assess environmental impacts on health and human services. HHS program managers use the results of these evaluations in the annual planning and budget process. The Department also sends the following annual reports to Congress that describe these evaluation activities: the Performance Improvement report, the Research, Demonstration, and Evaluation reports and the Public Health Service Evaluation Set-aside report. In addition, the Office of the Inspector General produces an annual Work Plan, identifying which program evaluations it will conduct in the upcoming year.

Program Assessment Rating Tool

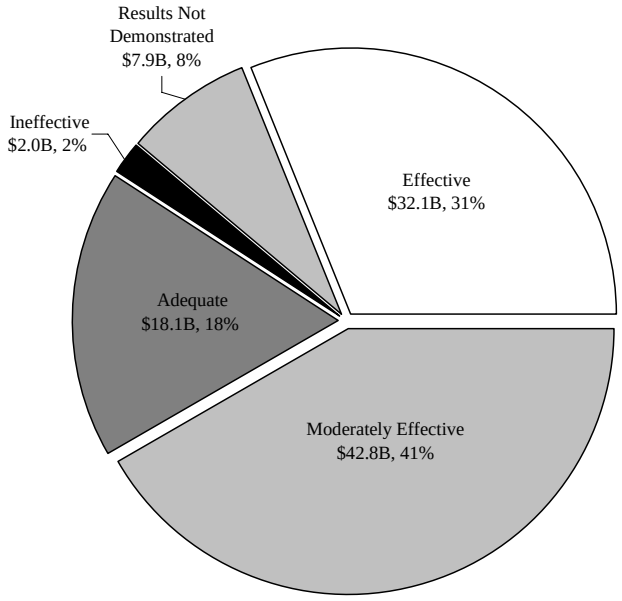
The Nation expects the projects and activities it funds to achieve results. A key gauge of Federal program effectiveness is the Program Assessment Rating Tool (PART), introduced in 2002. Its overall purpose is to assess program performance and results. The PART contains four sections: program purpose and design, strategic planning, program management, and program results. Programs receive narrative ratings of Effective, Moderately Effective, Adequate, Ineffective, and Results Not Demonstrated (RND).

HHS uses PART to inform management and budget decisions throughout the year. Programs use PART results and implement PART follow-up actions to improve program performance. Since 2002, 116 HHS programs have received a PART review; 25 of these in 2006. As represented by the charts below, the majority of HHS programs (weighted by budget dollar) received PART ratings of Adequate or higher. A list of the CY 2002 – CY 2006 HHS PARTed programs is located at the end of this document. For more detailed information on PART results for HHS programs, please see www.ExpectMore.gov.

HHS PART Ratings
All Programs



HHS PART Ratings
Excluding Medicare and Medicaid

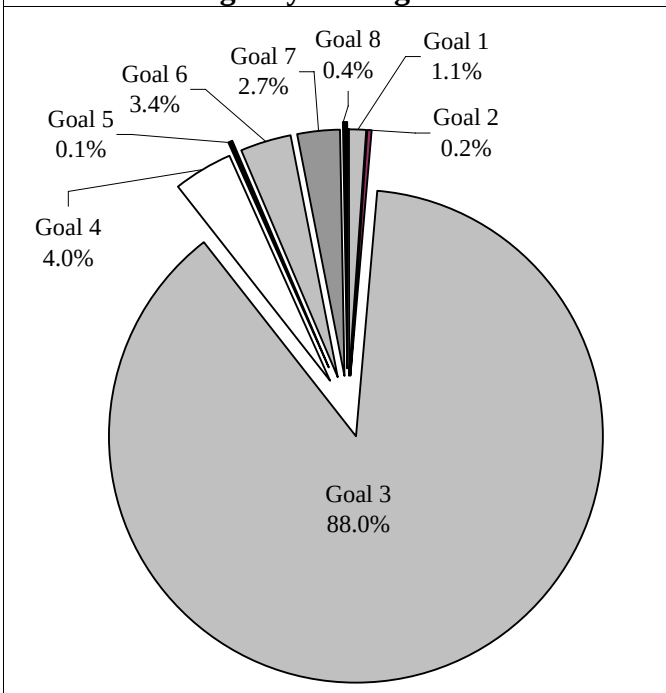


Values based on FY 2006 Enacted

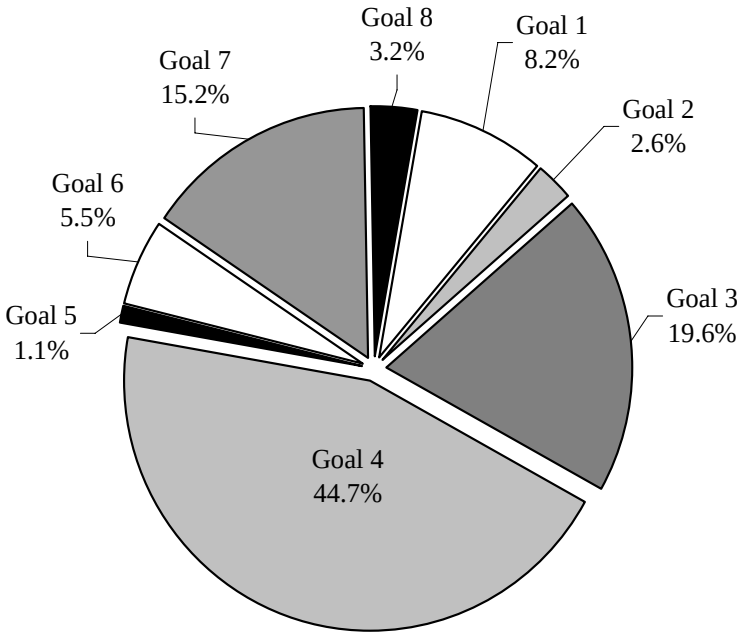
Budget by Strategic Goals

The work of each HHS Operating Staff and Division contributes to achieving the Department's eight strategic goals. The charts below show a breakdown of the total HHS budget and discretionary budget by HHS strategic goal. The total FY 2008 HHS budget is approximately $700 billion (in outlays) of which approximately 90 percent is mandatory and 10 percent is discretionary spending. Medicare and Medicaid account for almost 84 percent of the total mandatory spending and both programs support HHS Strategic Goal three. As a result, the total budget by strategic goal chart is heavily influenced by the size of the Medicare and Medicaid programs. This display should not be used to determine how much each program activity contributes to any one strategic goal since programs may in reality contribute to a number of strategic goals.

Percent of Total HHS Budget by Strategic Goal



Percent of Discretionary HHS Budget by Strategic Goal



Values based on FY 2008 President's Budget

President's Management Agenda

The PMA provides a framework that guides HHS, in conjunction with the Strategic Plan and the Secretary's priorities, in improving management and performance practices across the Department. Consisting of five broad Government-wide initiatives and four agency specific program initiatives, the PMA identifies critical management areas in which improvement will lead to better program results and add significant value for American taxpayers. Through implementation of the PMA, HHS has taken significant steps to institutionalize its focus on results and achieve improved program performance that is important to the HHS mission and the American taxpayer.

Each quarter, HHS is assessed on its recent accomplishments related to PMA initiative goals and receives scorecard ratings. The "status" rating indicates how well an Agency has performed in meeting the ultimate, long-term goals of the PMA. The "progress" rating measures an Agency's short-term, quarterly accomplishments that contribute to long-term success. The scorecards employ a grading system of "green" for full achievement of all goals for a particular initiative, "yellow" for intermediate achievement, and "red" when at least one deficiency is found.

The following table provides the HHS PMA results for the first quarter of FY 2007, which ended December 31, 2006.

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

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

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 commitment remains a critical priority for FY 2008. This goal supports the Department's vision to improve the health and well being of people in the United States 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 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.

1a. National Center for Immunization and Respiratory Diseases (CDC)

Description: The mission of the 317 Childhood Immunization program is to prevent disease, disability and death in children and adults through vaccination. The program provides grant support to State and local health departments in purchasing vaccines and conducting childhood immunization programs. The National Center for Immunization and Respiratory Diseases strives to prevent disease and disability through immunization and by control of respiratory and related diseases.

Performance Measure: *Achieve or sustain immunization coverage of at least 90 percent in children 19 to 35 months of age for: four doses Diphtheria, Tetanus, Acellular Pertussis (DTaP) vaccine, three doses Haemophilus influenzae (Hib) vaccine, one dose measles, mumps and rubella (MMR) vaccine, three doses hepatitis B vaccine, three doses polio vaccine, one dose varicella vaccine, four doses pneumococcal.*

Safe and effective vaccines are 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, routinely given as part of the childhood immunization schedule, found that vaccines are tremendously cost effective and these vaccines prevent nearly 14 million cases of disease and 33,000 deaths over the lifetime of children born in any given year. This has resulted in annual cost savings of $9.9 billion in direct medical costs and an additional $43.3 billion in indirect costs.

Past Performance and Future Targets

The target of 90 percent coverage was met in FY 2003, 2004, and 2005 for five of the seven vaccines. The two that did not meet the target were varicella and DTaP containing vaccine. Coverage rates are 96 percent for the first three DTaP doses. The fourth dose, given at an age for which regular well-baby visits are not as institutionalized as the visits in the first year of life, makes it difficult to achieve the 90 percent goal. Varying State requirements for the four-dose vaccine schedule may have also led to a slower increase in coverage. Varicella is the most recently introduced vaccine that has a measurable target. Varicella coverage rates have risen significantly from 43 percent in 1998 to 88 percent in 2005.

An unprecedented number of new or expanded vaccine recommendations will further reduce major threats to the health and well-being of Americans. As new vaccine recommendations are implemented, it becomes increasingly challenging to achieve and maintain the 90 percent childhood coverage target because of the complexity of the childhood vaccination schedule and the increasing cost to fully vaccinate one child with recommended vaccines.

FY 2006 data will be available in August 2007 after collection, analysis, and verification processes are completed. The FY 2008 target is to achieve or sustain immunization coverage of at least 90 percent in children 19 to 35 months of age.

Percent of Children Covered by Recommended Immunizations				
Year	**Target**	**Result**		
2003	90% coverage	DTaP 96% Hepatitis B 92%	Hib 94% Polio 92%	MMR 93% Varicella 85%
2004	90% coverage	DTaP 86% Hepatitis B 92%	Hib 94% Polio 92%	MMR 93% Varicella 88%
2005	90% coverage	DTaP 86% Hepatitis B 93%	Hib 94% Polio 92%;	MMR 92%; Varicella 88%
2006	90% coverage	8/2007		
2007	90% coverage	8/2008		
2008	90% coverage	8/2009		
Data Source: National Immunization Survey				

1b. HIV/AIDS Prevention in the United States (CDC)

Description: CDC's HIV activities include surveillance, research, intervention, capacity building, and evaluation. Research is conducted to better understand the factors that lead to HIV infection and identify effective prevention approaches. Intervention programs focus on communities most affected by the epidemic. Capacity building efforts aim to improve the ability of organizations to conduct effective programs and evaluation activities provide information for continuous improvement.

Performance Measure: *Reduce the rate of HIV infection cases diagnosed each year among people under 25 years of age.*

HIV infection cases diagnosed each year among persons less than 25 years of age are the best data available to monitor new HIV infections. HIV infections occurring in this group are likely to have been acquired recently and are a relatively good proxy measure of HIV incidence. In addition, these data enable CDC to look at annual trends in a meaningful way. This measure has been modified for FY 2008 to reflect rates rather than total numbers of cases. Rates may better reflect program performance over time, since the United States population continues to grow.

Data are from a national surveillance system that collects demographic, clinical, and behavioral information on all AIDS cases diagnosed in the United States, as well as HIV cases diagnosed in States with name-based HIV reporting requirements.

Past Performance and Future Targets

In FY 2003, performance targets were set for FY 2004 when only 25 States had stable, confidential name-based HIV reporting. Since that time, additional States have adopted name-based reporting methods and achieved stability in their data. As a result, five additional areas (including the United States Virgin Islands) were included in targets for FY 2006. Since FY 2004, eight additional States have been added to the target for FY 2008. In 2005, there were 3,605 HIV cases among those under 25 reported in 30 areas with confidential name-based reporting.

CDC has embarked upon a major initiative to increase the proportion of persons whose infection is diagnosed. This effort is expected to, in the near term, lead to increases in the number of cases that are reported to CDC. However, new infections are expected to decline in the long term as infected persons become aware of their infection and take steps to prevent transmission to others. Targets set for 2007 and 2008 have been adjusted accordingly. Data for 2006 needs will be available in November 2007, due to data collection, analysis, and verification processes. The target in FY 2008 is 8.6 new HIV infections diagnosed per 100,000 population under 25 years of age in 33 States.

Rate of HIV Infection Cases Diagnosed Among People Under 25 Years of Age		
Year	**Target**	**Result**
2003	Baseline Rate	2,286 in 25 States; 3,134 30 areas; 6.9/100,000
2004	Overall: 1,900 reported cases in 25 States	2,606 in 25 States; 3,465 in 30 areas; 7.2/100,000
2005	Overall: 1,800 reported cases in 25 States	2,700 in 25 States; 3,605 in 30 areas; 7.4/100,000
2006	Overall: 2,420 cases reported in 30 areas	11/2007
2007	<4,000 cases in 30 areas	11/2008
2008	8.6/100,000 in 33 States	11/2009
		Data Source: CDC Administrative Data

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

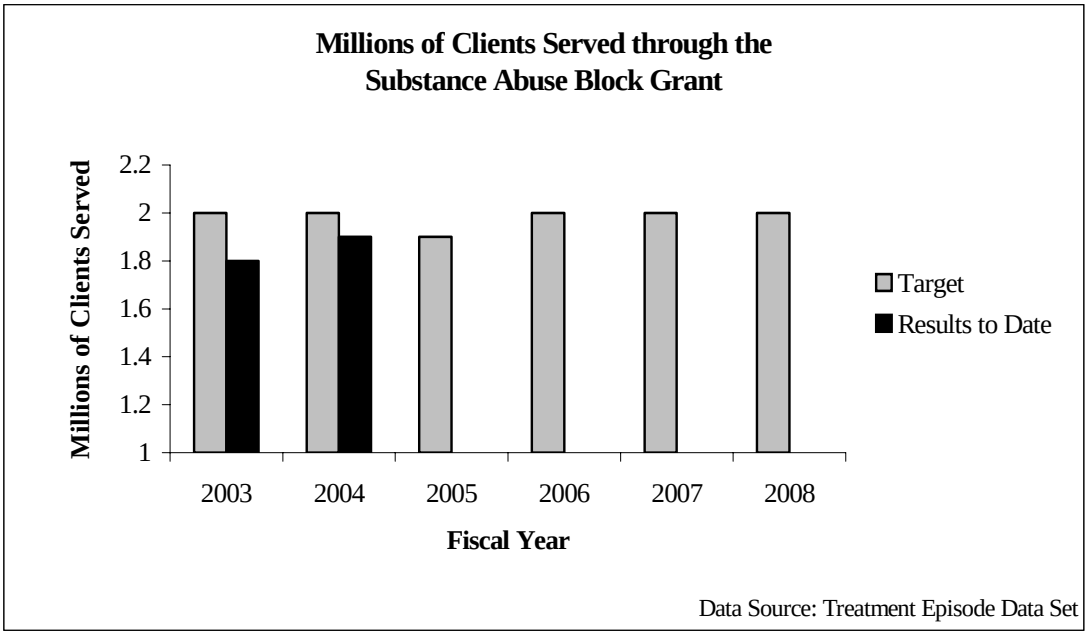
Description: The Substance Abuse Prevention and Treatment (SAPT) Block Grant provides funding to States by formula to plan, carry out, and evaluate activities to prevent and treat substance abuse. The SAPT Block Grant is the cornerstone of States' substance abuse programs.

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

The number of clients admitted for treatment is currently used as a proxy for this measure. Accordingly, readmissions to treatment for a single individual are counted as additional admissions. In the future, a data source capturing an unduplicated count of clients served will be available.

Past Performance and Future Targets

As displayed in the graph below, in FY 2004, 1,875,026 clients were served, an increase of 34,751 from the prior year. Data for FY 2005 will be available in October 2007. The FY 2008 target is to serve 1,995,244 clients.



STRATEGIC GOAL 2

Enhance the ability of the Nation's health care system to effectively respond to terrorism 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. To achieve this goal, HHS has taken efforts toward upgrading the capacity of the health care system to prepare for and respond to public health threats, especially bioterrorism, and taking steps to improve the safety of food, drugs, biological products, and medical devices.

This report highlights three programs, including the Food and Drug Administration's (FDA) Field Food Program, the Centers for Disease Control and Prevention's (CDC) Terrorism Preparedness and Emergency Response Program, and the Office of Public Health and Science's (OPHS) Commissioned Corps Readiness and Response program.

2a. Field Foods Programs (FDA)

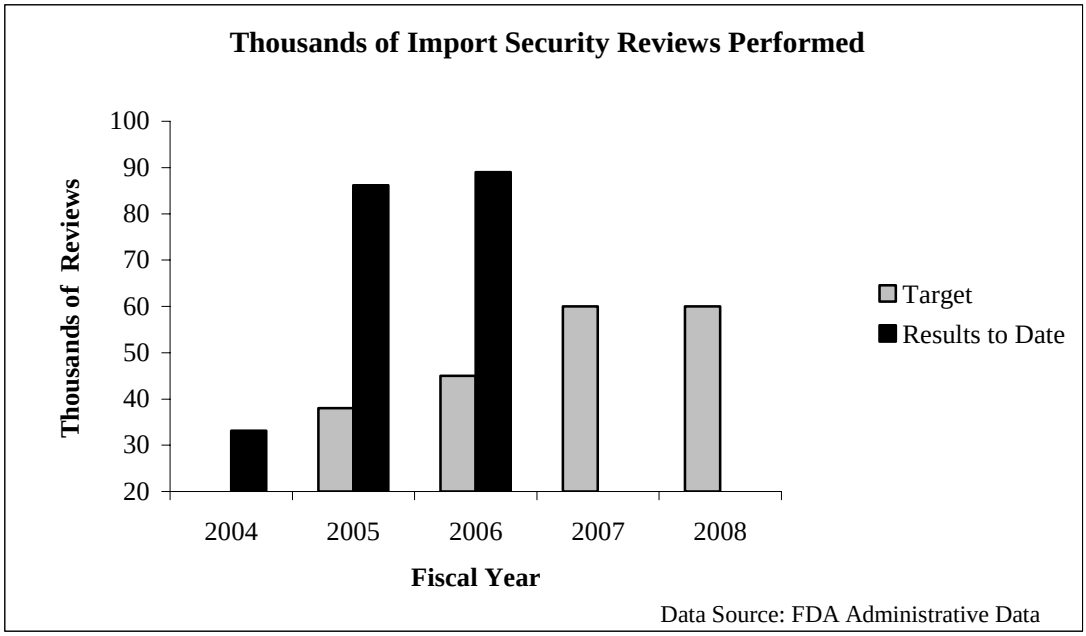
Description: FDA's Prior Notice Center was established in response to regulations promulgated in conjunction with the Public Health Security and Bioterrorism Preparedness Act of 2002. The Prior Notice Center's mission is to identify imported food products that may be intentionally contaminated with biological, 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.

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

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. A security review is an intensive manual risk assessment that includes a determination of the adequacy and accuracy of prior notice data for high-risk imported food products. The Prior Notice Center Reviewer conducts the security review using electronic databases and other information sources to determine whether or not the shipment poses a significant security risk to the United States food supply. 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.

Past Performance and Future Targets

FDA has increased the number of security reviews each year since the measure was first established in 2004. The baseline in 2004 was established at 33,111 reviews. 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. The FY 2008 target is to perform 60,000 security reviews.



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

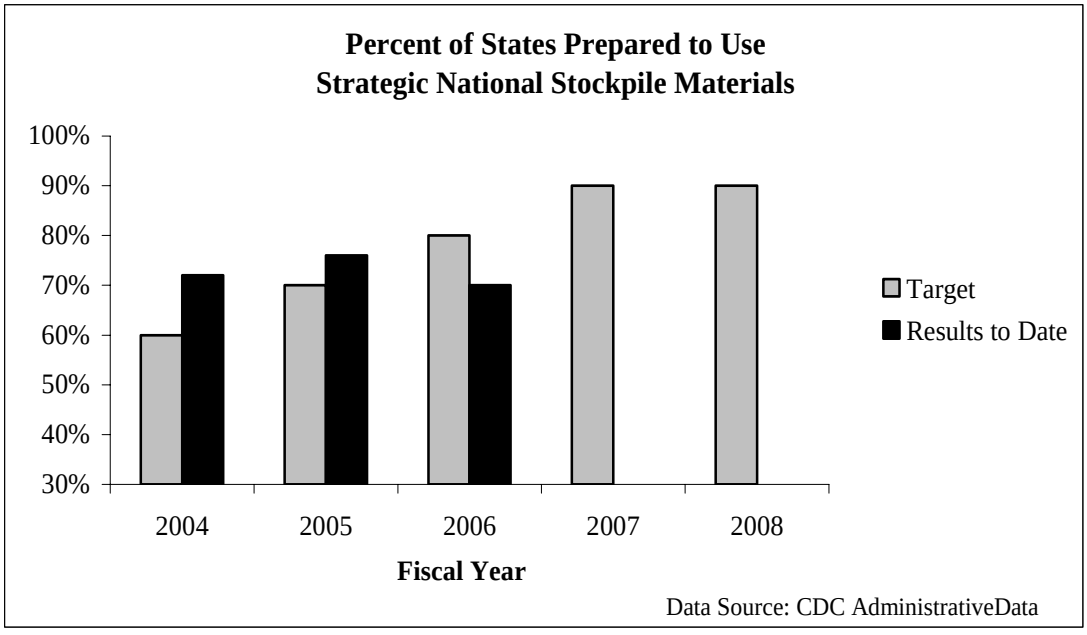
Description: The Strategic National Stockpile (SNS) is a national repository of life saving pharmaceuticals, medical material, and equipment. The SNS permits HHS to respond to mass trauma events by delivering medical supplies to any point in the United States within 12 hours.

Performance Measure: *100 percent of State public health agencies are prepared to use material contained in the Strategic National Stockpile as demonstrated by evaluation of standard functions as determined by CDC.*

Past Performance and Future Targets

Historically, the results of CDC's assessment of grantee assessments of SNS preparedness have exceeded performance targets, as illustrated by the figure. During FY 2006, in an effort to increase grantee preparedness to effectively manage and use deployed SNS material, more rigorous assessments were conducted. Preparedness functions, standards, and tools were revised to clearly define expectations to meet specific qualifiers for each element. Enhanced assessments, planning efforts, technical assistance, training, and exercises will all contribute to improved performance during a public health emergency. At the end of FY 2006, 70 percent (38/54) of the States and directly-funded cities demonstrated preparedness to use SNS assets, not reaching the 80 percent target.

The primary challenge continues to be recruitment, and training of staff and volunteers to execute a mass prophylaxis plan due to a number of competing priorities and initiatives at the State and local level. Improved coordination between State and local agencies that are responsible for disaster preparedness is also a continuing challenge. Although more stringent standards and challenges may cause grantee status to fluctuate, the SNS program remains committed to the long term measure of 100 percent and the incremental targets for improving preparedness in FY 2007 and 2008. The Cities Readiness Initiative which provides special funding to targeted cities and metropolitan areas to assist with the delivery of medicines and medical supplies during a large-scare public health emergency, and the State Pandemic Influenza Summits which bring together public health emergency management and response leaders are among the dedicated efforts contributing to meeting the targets. The FY 2008 target is to achieve a level of 90 percent of grantees meeting the minimum standards.



2c. Commissioned Corps Readiness and Response (OPHS)

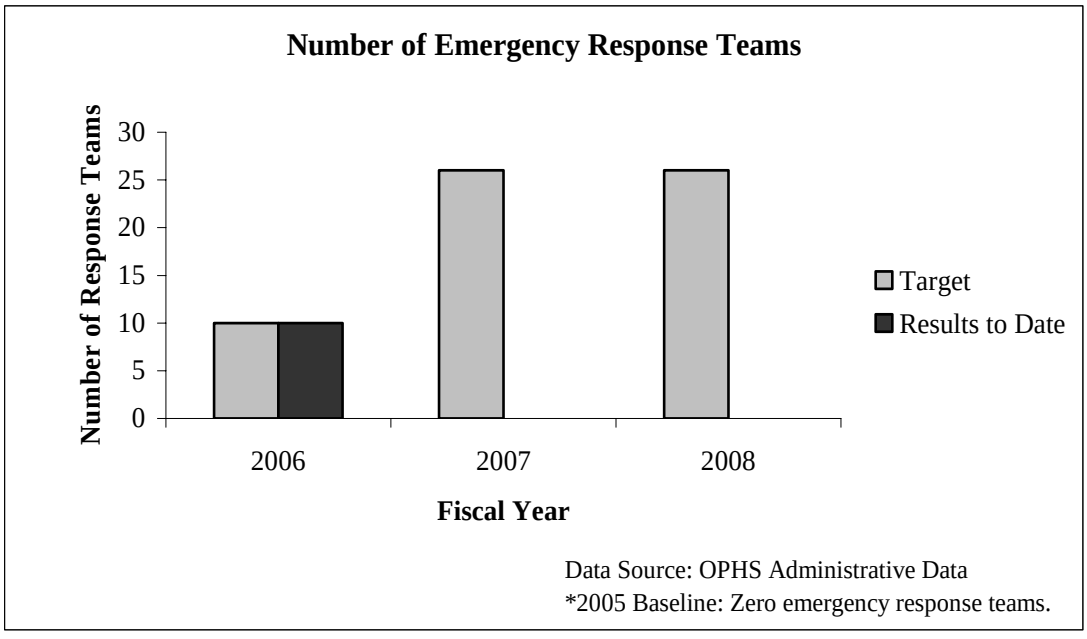
Description: One of the seven United States Uniformed Services, the United States Public Health Service Commissioned Corps protects, promotes, and advances the health and safety of the Nation. The Commissioned Corps is the primary asset for HHS to effectively respond to bioterrorism and other public health challenges.

Performance Measure: *Increase the number of response teams formed, thus enhancing the Department's capability to rapidly and appropriately respond to medical emergencies and urgent public health needs.*

In order to protect the health of the American people, the Secretary is dedicated to transforming the Commissioned Corps into a force that is ready to respond to public health challenges and health care crises.

Past Performance and Future Targets

After meeting the FY 2006 target of forming 10 response teams, as illustrated in the figure below, HHS established a new paradigm for operational preparedness of the Corps. The new response structure consists of an increased number of organized, tiered teams. As of January 2007, 25 response teams have been created. To achieve full operational status, each team must be fully equipped and trained. At this time, 15 teams have met minimum training standards and 10 of the teams have the required equipment. HHS is also considering the need for teams to have more aggressive training. The FY 2008 target is to advance the teams formed in FY 2007 to the next level of 26 fully trained and equipped teams in FY 2008.



Data Source: OPHS Administrative Data
*2005 Baseline: Zero emergency response teams.

STRATEGIC GOAL 3

Increase the percentage of the Nation's children and adults who have access to health care services, and expand consumer choices

HHS is committed to increasing the percentage of the Nation's children and adults who have access to care and to expanding consumer choices. In FY 2008, the Department will continue to work hard to promote increased access to health care, especially for uninsured and underserved people and for those whose health care needs are not adequately met by the private health care system.

In support of this goal, HHS will continue to promote a wide variety of activities intended to increase access to health care, encourage the development of low-cost health insurance options, reduce health disparities, and to strengthen and improve health care services for targeted populations with special health care needs. Seven programs are highlighted in this strategic goal, including: the Health Resources and Services Administration's (HRSA) Ryan White and Health Centers programs, the Indian Health Services' (IHS) National Diabetes program, the Substance Abuse and Mental Health Services Administration's (SAMHSA) Children's Mental Health Services program, and the Centers for Medicare & Medicaid Services' (CMS) Medicare and Medicaid programs.

3a. Ryan White Program (HRSA)

Description: The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act funded programs ensure care and treatment for persons with HIV/AIDS through assistance to localities disproportionately affected by HIV/AIDS. The funding goes to States, metropolitan areas, and other public, private, and nonprofit entities to support their local activities.

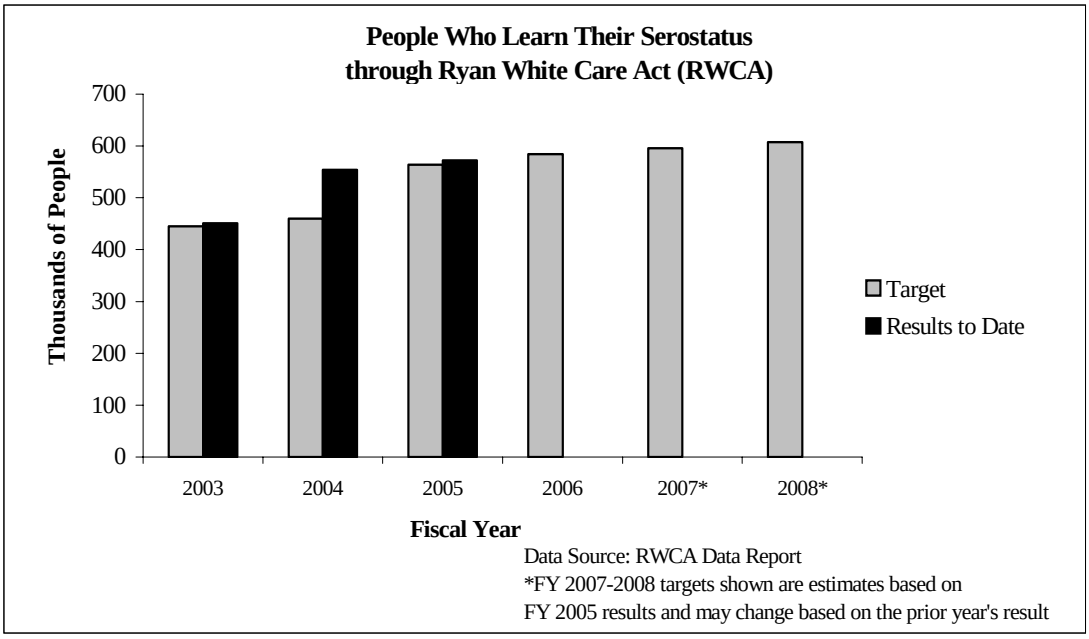
Performance Measure: *Increase by two percent annually, the number of persons who learn their serostatus from Ryan White CARE Act programs.*

An important component of the care provided through Ryan White funded programs is informing persons of their serostatus (HIV status) following testing. Serostatus is the condition of having or not having detectable antibodies to a microbe in the blood as a result of HIV infection. 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. The CDC estimates that 1.0 million to 1.2 million people in the United States are living with HIV/AIDS, of whom an estimated 24 to 27 percent are unaware of their serostatus. The program aims to increase annually the number of persons who learn of their serostatus through Ryan White CARE Act service providers.

People who are tested for HIV but fail to return for their test results lose out on the benefits of early treatment. Therefore, providers also work to facilitate patient follow-up for test results and care. Ryan White CARE Act providers target HIV testing efforts to populations determined, through review of local epidemiologic and service data, to be at disproportionate risk for HIV infection. Testing is conducted in a manner (e.g., time of day, events, sites, methods, cultural appropriateness) that is designed to encourage and facilitate the participation of these populations in testing.

Past Performance and Future Targets

In FY 2003 the program provided nearly 451,000 persons confirmation of their serostatus. This number increased to more than 553,000 in FY 2004 and to more than 572,000 in FY 2005. Performance exceeded targets each of these years. The target for FY 2008 is an increase of two percent above the FY 2007 results. FY 2008 results are expected in February 2010.



3b. Health Centers Program (HRSA)

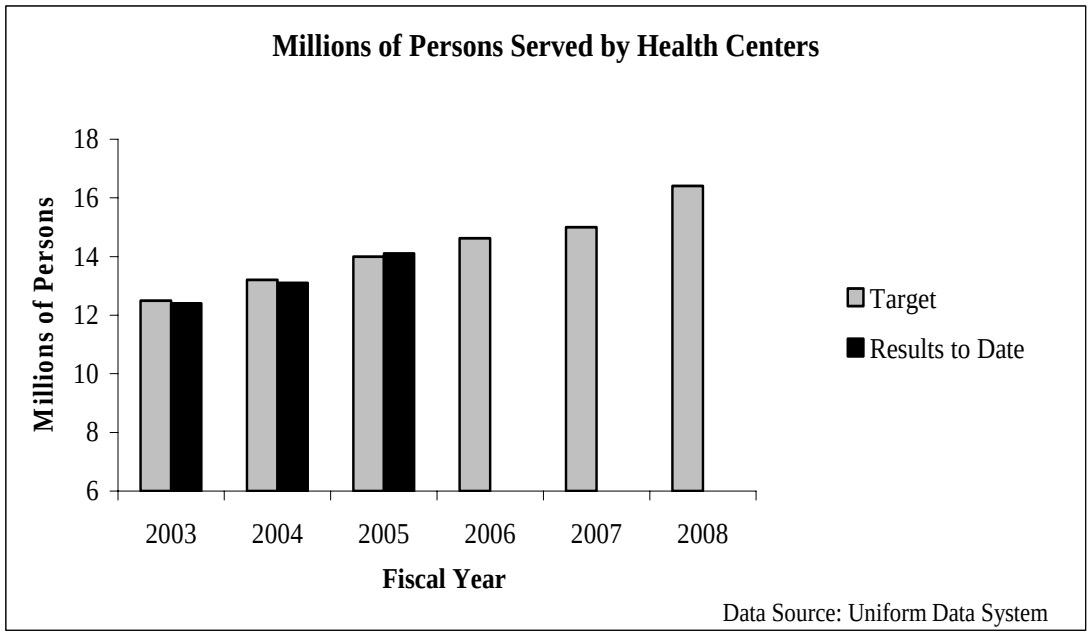
Description: This program provides grants to health centers to provide medical care to uninsured and underserved populations in rural and urban areas.

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

Growth in the number of persons served by health centers is a key indicator of expanded access to care and increased availability of services for the Nation's most vulnerable populations.

Past Performance and Future Targets

Since the beginning of the President's Health Center Initiative in 2002, there has been an increase in health care access for those Americans most in need through the creation of new or significantly expanded health center sites. 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. Building upon this, the FY 2008 target number of uninsured and underserved persons to be served by Health Centers is 16.3 million. FY 2008 results are expected in August 2009.



3c. National Diabetes Program (IHS)

Description: The mission of the IHS National Diabetes Program is to develop, document, and sustain a public health effort to prevent and control diabetes in American Indians and Alaska Natives (AI/AN).

Performance Measure: *Reduce complications of diabetes by increasing the proportion of patients with diagnosed diabetes that have achieved blood pressure control (<130/80).*

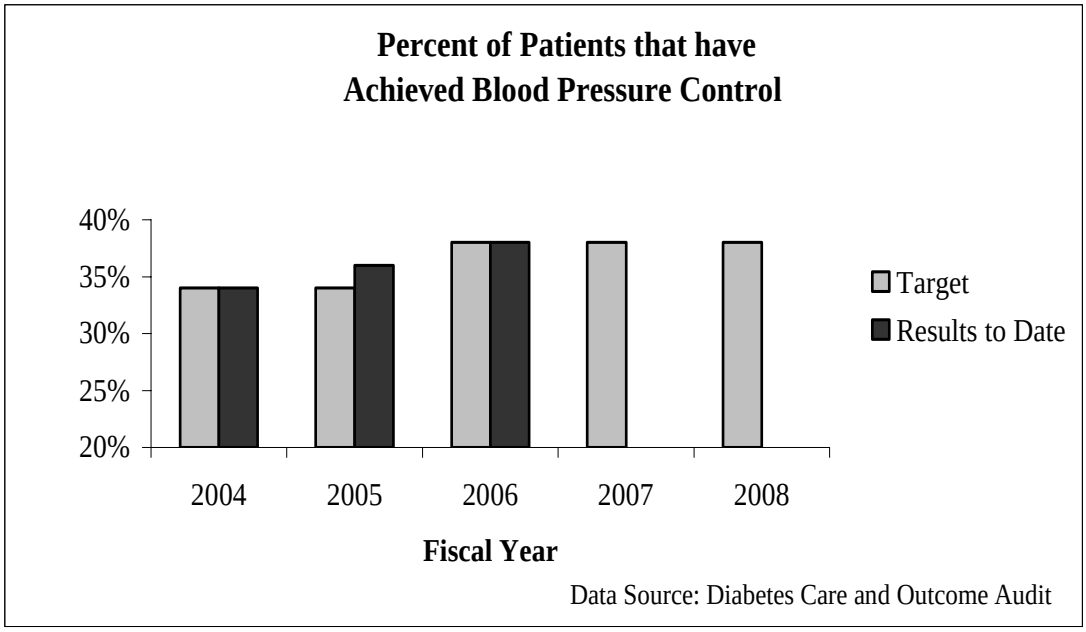
This measure is directed at reducing complications of diabetes. Research has shown that coronary heart disease events, stroke, and kidney disease from diabetes can be reduced by lowering blood pressure to <130/80 in persons with diabetes. Lower blood pressure levels in people with diabetes reduce the risk of heart disease and stroke by 33 to 50 percent. In 2003, nearly 70 percent of AI/AN with diabetes and aged 35 years or older also had hypertension.

IHS tracks this measure using the Annual Diabetes Care and Outcomes Audit. Participation in the Audit is voluntary (although strongly encouraged). The validity and reliability of its statistical data are maximized by uniform data collection and reporting procedures.

IHS has met this measure based on the IHS Diabetes Care and Outcomes Audit data since FY 2001. This achievement is even more noteworthy given that the benchmark for blood pressure control standards for people with diabetes has been tightened during this time period. Prior to 2001, ideal blood pressure for a person with diabetes was considered to be <130/85 and controlled blood pressure <140/90. Since 2001, IHS lowered the acceptable diastolic blood pressure from 85 mmHg to 80 mmHg and the acceptable systolic blood pressure from 140 mmHg to 130 mmHg in response to new National Guidelines on Blood Pressure Control in people with diabetes. Large clinical trials have shown that blood pressure control may be difficult in the person with diabetes and can often require three to five medications in combination to achieve acceptable blood pressure control. Moreover, many facilities in the AI/AN health system cannot afford the high cost of newer, more effective blood pressure medications for people with diabetes. Consequently, many AI/AN patients are unable to achieve the full benefit of blood pressure control otherwise attainable with the availability of these medications. Despite the difficulty of achieving ideal blood pressure control in people with diabetes, no performance goal changes have been made.

Past Performance and Future Targets

The graph provided demonstrates a sustained positive trend in blood pressure control improvement since FY 2003 as demonstrated by the Annual Diabetes Care and Outcomes Audit data. The FY 2006 indicator was to maintain the proportion of AI/AN patients with diabetes that have achieved blood pressure control from FY 2005. IHS met and surpassed the FY 2006 blood pressure control indicator by two percent in the 2006 IHS Diabetes Care and Outcome Audit results. The FY 2007 target is to maintain the FY 2006 performance level (38 percent of patients with diabetes demonstrating blood pressure control for the Diabetes Audit). The target for FY 2008 is to maintain the FY 2007 level of performance. The date of expected results for FY 2008 is October 2008.


Percent of Patients that have
Achieved Blood Pressure Control
40%
35%
30%
25%
20%
2004
2005
2006
2007
2008
Fiscal Year
Target
Results to Date
Data Source: Diabetes Care and Outcome Audit

3d. Children's Mental Health Services (SAMHSA)

Description: Children's Mental Health Services makes competitive grants to State and local governments to support community mental health services for children with serious emotional disturbance.

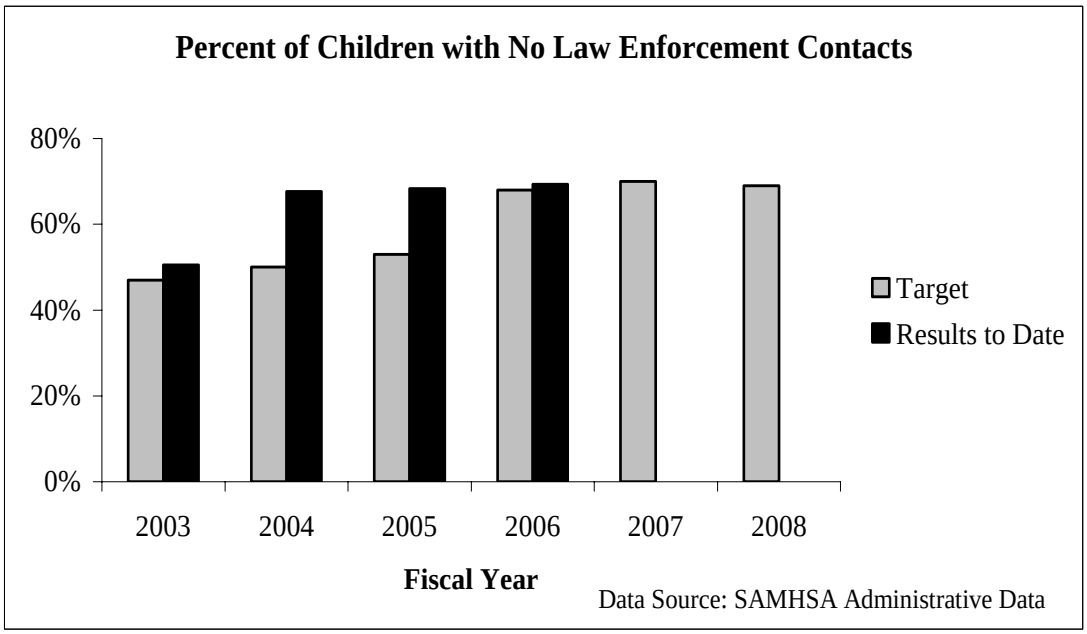
Performance Measure: *Improve children's outcomes and systems outcomes: Increase percentage of participants with no law enforcement contacts at six months.*

Children's Mental Health Services increases access to health care services by improving and expanding mental health care available in grantee areas. The highlighted performance measure captures positive behavioral outcomes for program participants.

Past Performance and Future Targets

As displayed in the graph below, in FY 2006, 69.3 percent of children had no law enforcement contacts at six month follow-up, exceeding the target of 68.0 percent. Performance on this measure has improved from half of program participants (50.5 percent in FY 2003) to more than two-thirds of participants (69.3 percent in FY 2006) reporting no law enforcement contacts at six month follow-up.

Grantees vary in the populations they target. Grantees that target high-risk and/or older children face greater challenges in achieving some outcomes, including reductions in law enforcement contacts. As a result, the performance results for this measure are affected by the mix of grantees and individuals served in any given year. The FY 2008 performance target is for 68 percent of participants to have no law enforcement contacts at six months.



3e. Medicare Prescription Drug Program (CMS)

Description: Medicare finances health insurance for eligible elderly and disabled individuals. As of January 1, 2006, the Medicare benefit includes outpatient prescription drug coverage.

Performance Measure: *Implement the new Medicare Prescription Drug Benefit.*

A. Knowledge of Prescription Drug Coverage*: percentage of people with Medicare that know that people with Medicare will be offered/are offered prescription drug coverage starting in 2006.*

B. Knowledge of Out-of-Pocket Costs*: percentage of beneficiaries that know that out-of-pocket costs will vary by the Medicare prescription drug plan.*

C. Knowledge of Formulary*: percentage of beneficiaries that know that all Medicare prescription drug plans will not cover the same list of prescription drugs.*

The initial enrollment period for the new Medicare prescription drug coverage began on November 15, 2005 and ended on May 15, 2006. As of June 2006, more than 38 million enrolled Medicare beneficiaries began to fill prescriptions using the new Medicare prescription drug benefit. Beneficiary awareness and knowledge of the new benefit is not only vital to the success of the program, but also ensures that beneficiaries receive the proper coverage for their Medicare needs.

Past Performance and Future Targets

Since CMS was successful in meeting its FY 2006 targets (listed in the table below), the targets were increased for FY 2007 and beyond. FY 2008 targets are: (A) 63 percent, (B) 65 percent, and (C) 46 percent; results are expected September 2008.

Beneficiary Knowledge of the New Medicare Prescription Drug Benefit

	Knowledge of					
	A: Prescription Drug Coverage		B: Out-of-Pocket Costs		C: Formulary	
Year	Target	Result	Target	Result	Target	Result
2005	47%	47%	50%	50%	27%	27%
2006	67%	67%	69%	69%	50%	50%
2007	62%	9/2007	64%	9/2007	45%	9/2007
2008	63%	9/2008	65%	9/2008	46%	9/2008

Data Source: 2005-2006: National Medical Education Program Assessment Survey
2007-2008: New tracking surveys

3f. Medicare Program (CMS)

Description: Medicare finances health insurance for eligible elderly and disabled individuals. As of January 1, 2006, the Medicare benefit includes outpatient prescription drug coverage.

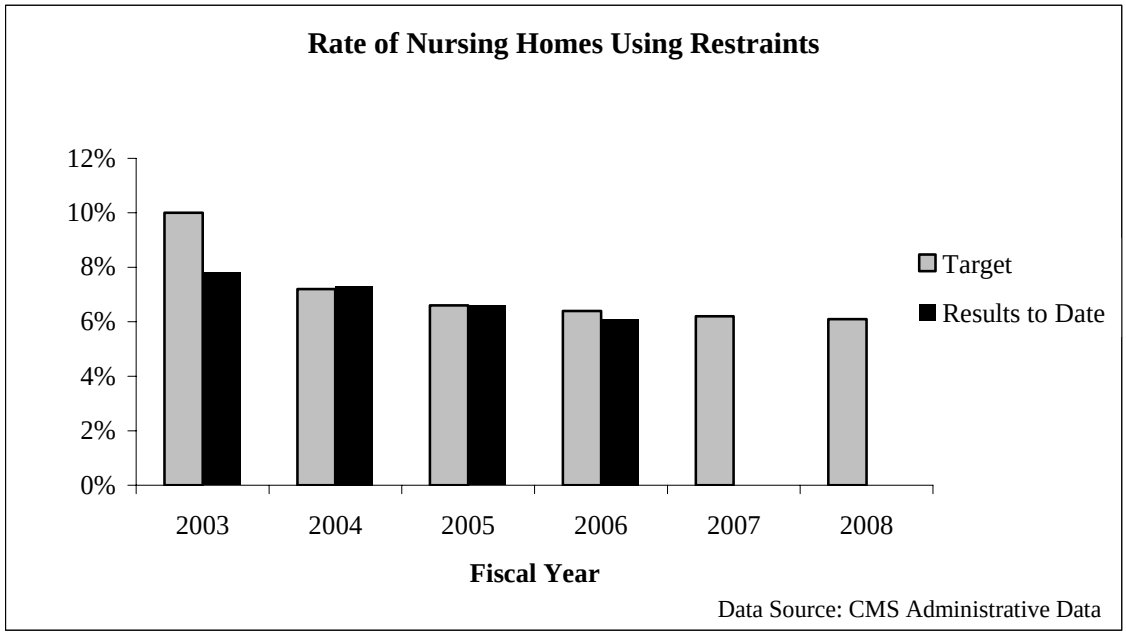
Performance Measure: *Decrease the Prevalence of Restraints in Nursing Homes.*

In establishing quality of care performance measures, CMS focused on measures that have been recognized as clinically significant and/or closely tied to care given to beneficiaries. Individuals in nursing homes are a particularly vulnerable population, and consequently, CMS places considerable importance on nursing home quality measures. Both the Medicare and Medicaid programs support nursing home quality of care efforts.

"Physical restraints" are defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily and that restricts freedom of movement or normal access to one's body. The reduction in the use of physical restraints in nursing homes has been one of CMS' major quality initiatives. The prevalence of physical restraints is an accepted indicator of quality of care and may be considered a quality of life measure for nursing home residents. The use of physical restraints can cause incontinence, pressure sores, loss of mobility, and other morbidities.

Past Performance and Future Targets

The prevalence of physical restraints in nursing homes has decreased steadily since FY 1996. Although the prevalence of physical restraints continues to decline, it is doing so at a slower rate. This reflects the fact that many nursing homes have achieved low restraint rates. Those that have not will require particularly energetic interventions to reduce the use of physical restraints. As highlighted in the graph below, CMS efforts with the State surveyors have helped the rate to continuously decrease. In FY 2005, 6.6 percent of nursing homes reported using restraints. The FY 2008 target is 6.1 percent; results are expected February 2009.



3g. Medicaid Program (CMS)

Description: Authorized under Title XIX of the Social Security Act, Medicaid is a means-tested health care entitlement program financed by States and the Federal Government that provides medical assistance on behalf of families with dependent children, pregnant women, children, and aged, blind and disabled individuals.

Performance Measure: *Number of States that demonstrate improvement related to access and quality health care.*

The aim of the Medicaid Quality Improvement Program includes supporting States in achieving safe, effective, efficient, timely, equitable, and patient-centered care. CMS will use information gained from these State-level quality improvement initiatives as building blocks for the development of a larger, national-level quality framework.

CMS partners with States and other nationally recognized organizations to provide technical assistance and disseminate best practice information identified through performance measurement reporting and external quality reviews. CMS will help States better assess and enhance quality strategies for improving health care to Medicaid beneficiaries.

Past Performance and Future Targets

In the fall of 2006, CMS held a technical web-conference for State Medicaid representatives and regional CMS offices to discuss opportunities identified to improve State Medicaid Quality Program Strategies, Performance Improvement Projects, and Medicaid Demonstration Program evaluations. Technical assistance was provided through distribution and discussion of Medicaid Quality Tool Kits recently developed by CMS. Additionally, the conference provided information on nationally recognized organizations such as the Commonwealth Fund and the Center for Health Care Strategies, and their initiatives and opportunities for supporting States in improving the quality of their Medicaid programs.

Additional tools will be developed over the course of FY 2007, along with the development of tracking mechanisms for monitoring States' assessments of access and quality improvement. The FY 2008 target is to have 15 percent (8 States) participating in the Medicaid Quality Improvement Program; results are expected March 2009.

State Improvement of Medicaid Access and Quality Health Care		
Year	**Target**	**Result**
2007	Baseline – 0 States (0%)	2/2008
2008	8 States (15%)	3/2009
		Data Source: State performance reports

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 in achieving its other strategic goals incorporate a research base. This goal focuses on creating the underlying knowledge and strategies that improve and maintain the research infrastructure that produces advances in health science. Three of the National Institute of Health's (NIH) research efforts are highlighted in this strategic goal including HIV/AIDS Vaccine Research, the National Institutes of Neurological Disorders and Stroke, and the National Institute on Drug Abuse.

4a. HIV/AIDS Vaccine Research (NIH)

Description: Safe and efficacious vaccines are essential for global control of the AIDS pandemic. NIH supports a broad program encompassing basic, preclinical, and clinical research on candidate vaccine products.

Performance Measure: *By 2010, develop an HIV/AIDS vaccine.*

The HIV/AIDS pandemic has killed more than 25 million people, surpassing tuberculosis and malaria as the leading infectious cause of death worldwide. In 2005, an estimated 40.3 million of the world's population, including 2.3 million children younger than 15 years of age, were living with HIV/AIDS. As promising candidates move further in the vaccine pipeline, expanded clinical trials will become increasingly important. NIH is designing and testing new vaccine candidates based on research findings on the structural components of HIV and on studies of immune responses in small animals and nonhuman primates (NHPs).

A significant investment of NIH resources has been made in new and improved product designs to ensure that there is a vibrant pipeline to support HIV vaccine development efforts. NIH continues to increase support for a broad program encompassing basic, preclinical, and clinical research on candidate vaccine products.

Past Performance and Future Targets

Prospective annual measures have been designated to achieve the goal by the specific timeframe indicated. However, annual measures may be adjusted due to a variety of external factors, such as budget changes and/or scientific discoveries. Budget changes may require performance or timeframe adjustments that are aligned with available funds. Also, specific annual projections may require adjustments as current year discoveries materialize, since each year builds the subsequent year. These adaptations create the best science and ensure progression of the scientific field.

Progress Toward Developing an HIV/AIDS Vaccine		
Year	**Target**	**Result**
2003	Design and develop new or improved vaccine strategies and delivery/production technologies.	Four newly identified vaccine strategies increased scientific knowledge of how AIDS causes disease and the immune response to it.
2004	Initiate one to two multinational trials in collaboration with private companies, academic investigators, other government agencies and scientists in resource-poor countries.	Two multinational trials initiated in collaboration with private companies, academic investigators, other government agencies and scientists in resource-poor countries.
2005	Initiate four new Phase I or II trials of new or improved concepts and designs and expand capacity to conduct clinical trials in three international sites.	NIH initiated five phase I trials for new products and six phase I and one phase II trials to further assess existing products. NIH expanded clinical trial capacity into eight new international settings.
2006	Initiate one new phase IIb trial to determine if a third generation vaccine candidate has efficacy.	NIH initiated a Phase IIb study (test of concept) to evaluate the safety and efficacy of Merck's Adenovirus serotype 5 HIV-1 gag/pol/nef vaccine in high-risk adults.
2007	Initiate another Phase II/IIb trial(s) of the most promising third generation vaccine candidate.	12/2007
2008	Initiate a Phase IIb trial of a promising vaccine candidate that may protect across viral clades (or subtypes).	12/2008
		Data Source: NIH Administrative Data

4b. National Institute of Neurological Disorders and Stroke (NIH)

Description: The prevalence of stroke risk factors and the potential impact of reducing those factors vary among racial/ethnic groups. There is a potentially greater impact associated with reduction or elimination of these risk factors for minorities. Prevention programs are a preferred strategy for reducing or eliminating racial/ethnic disparities in stroke and include both primary and secondary approaches.

Performance Measure: *By 2010, identify culturally appropriate, effective stroke prevention programs for nationwide implementation in minority communities.*

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. American Indians/Alaska Natives, the relative risk is almost 2 times higher at ages 35 to 44, 1.3 times higher at ages 45 to 54 and 1.5 times higher at ages 55 to 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 two stated goals of Healthy People 2010, 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. This performance goal will ultimately lead to the identification of effective stroke prevention and intervention strategies for a variety of community settings. Much needed stroke-related epidemiological data in racial/ethnic minority communities will be collected. Stroke prevention research projects will be conducted to include community-based interventions, epidemiology, and/or outcome measures.

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.

Progress Identifying Effective Stroke Prevention Programs		
Year	**Target**	**Result**
2003	Establish a five-year program to create about 12 to 14 Partnership Centers to Reduce Health Disparities that will focus on influential factors that reduce health disparities.	Seventeen Nursing Partnership Centers established to reduce health disparities, including stroke, which link research-experienced nursing schools with minority-serving nursing schools across the nation.
2004	Establish a minority-focused, acute stroke research and care center to conduct a study of the epidemiology of stroke, barriers to acute stroke care, and quality of care within the specific racial/ethnic communities being served by the care center.	Acute stroke care center serving a minority community in the Washington, DC metropolitan area has been established.
2005	Establish the infrastructure for a Stroke Prevention and Intervention Research Program (SPIRP) at a minority institution.	Established research infrastructure and advisory committees, and hired director for SPIRP.

Progress Identifying Effective Stroke Prevention Programs		
Year	**Target**	**Result**
2006	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 and began enrolling patients.
2007	Initiate at least two collaborative, community-based prevention projects at the SPIRP.	12/2007
2008	Establish a database of stroke patients and collect data for the purposes of identifying new stroke risk factors and developing effective stroke prevention strategies.	12/2008
		Data Source: NIH Administrative Data

4c. National Institute on Drug Abuse (NIH)

Description: Although research has demonstrated that drug abuse treatment can be effective in reducing drug use and addiction, including alcoholism, few science-based interventions have been developed and tested widely within the health care field. To move research forward in this arena, new drug abuse treatment approaches focusing on behavioral treatment, which has been documented to be effective in improving drug abuse and drug addiction outcomes, will be tested within community-based settings.

Performance Measure: *By 2008, develop and test new evidence-based treatment approaches for drug abuse in community settings.*

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 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.

Progress Toward Developing Treatment Approaches for Drug Abuse		
Year	**Target**	**Result**
2004	Adapt two treatment approaches from small-scale research settings to community-based settings for the purpose of bringing research-based treatments to communities.	Three treatments have been adapted for community-based settings.
2005	Build capacity for targeted treatments by training 90 treatment providers to: (a) participate in clinical trials to promote treatment fidelity; and (b) deliver evidenced-based behavioral treatment to target populations in community settings.	The Clinical Trials Network has trained 184 providers (94 more than planned) in Brief Strategic Family Therapy, or Seeking Safety, which are being tested in community settings.
2006	Recruitment will be completed of approximately 1,000 patients from specialized populations to test the efficacy of community-based treatments.	The Clinical Trials Network has enrolled more than 1,200 patients in BSFT, MET, and Seeking Safety interventions which are being tested in community settings. Treatments are being delivered to diverse communities that are 20%, 34%, and 41% African American, respectively, and 43%, 7%, and 14% Hispanic, respectively.

Progress Toward Developing Treatment Approaches for Drug Abuse		
Year	**Target**	**Result**
2007	Analyze data from completed behavioral protocols and report initial findings from data analysis.	12/2007
2008	Complete development and testing of two new evidence-based treatment approaches for drug abuse in community settings.	12/2008
		Data Source: NIH Administrative Data

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

This strategic goal highlights three programs including Food and Drug Administration's (FDA) Human Drugs program, and the Health Information Technology programs in both the Agency for Healthcare Research and Quality (AHRQ's) and the Office of the National Coordinator for Health Information Technology (ONC).

5a. Human Drugs Program (FDA)

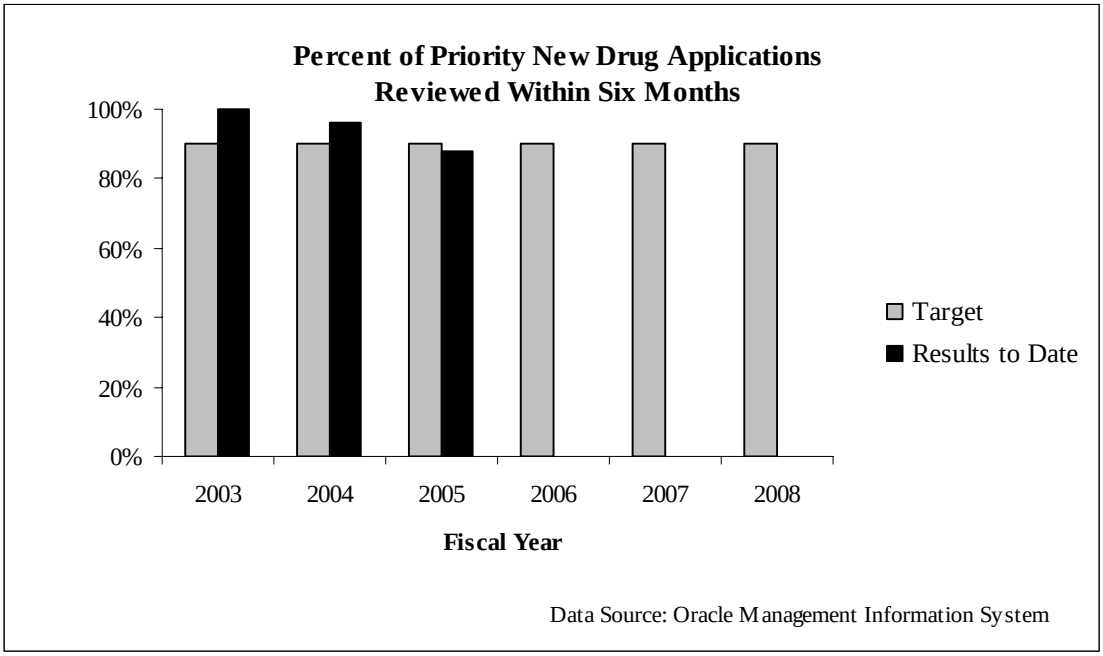
Description: The Human Drugs program ensures the safety and efficacy of existing human drugs, helping to make medicines safer, more affordable, and more available. FDA evaluates all new drugs for safety and efficacy before they enter the market, and also monitors safety and efficacy of the more than 10,000 drugs that are already on the market.

Performance Measure: *Percentage of Priority New Drug Applications (NDAs) reviewed within six months.*

FDA's review of NDA's 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 (which are applications to market drugs that are very similar to products already on the market) represent drugs that offer significant advances over existing treatments. For example, drugs for the treatment of 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.

Past Performance and Future Targets

FDA has consistently met, or has come close to reaching this goal in the past, and the timely achievement of high-quality drug reviews in recent years reflects the importance of managerial reforms and additional resources provided under the Prescription Drug User Fee Act. 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, and it is anticipated that the results for FY 2006 will be available in July 2007. The FY 2008 target is to review 90 percent of Priority NDA within six months.



5b. Health Information Technology (AHRQ)

Description: AHRQ's health IT efforts are designed to demonstrate the importance of patient safety reporting systems, computerized provider order entry, and decision support systems to key stakeholders and policymakers. AHRQ also examines the best ways to develop, deploy, and evaluate the use of electronic health information systems, both the technology and the processes around it, by addressing systemic barriers to adoption and creating the evidence base for best practices.

Performance Measure: *By 2014, most Americans will have access to and utilize a Personal Electronic Health Record (EHRs).*

Americans must have ready access to their personal health information in order to receive timely, efficient, effective and safe health care. AHRQ's Health IT portfolio promotes education about, and demonstration of, personal EHRs to improve health care safety and quality.

EHR and the Personal Health Record (PHR) are significant and important tools to improve the quality, safety and efficiency of care. Both offer providers and patients a powerful mechanism to understand and manage increasingly complex and disparate medical information. The administration determined that access to personal EHRs is a key component to improving care. However, before this goal can become reality, a number of challenges and barriers must be overcome. AHRQ projects and programs are presently informing both public and private stakeholders regarding successful strategies to overcome these obstacles.

Past Performance and Future Targets

For 2007, AHRQ is soliciting applications for multiyear research demonstration grants advancing patient-centered care using health IT. In addition to grant projects, AHRQ plans to contract for a recurring assessment of nationwide access to and use of personal EHRs. AHRQ is developing a public online consumer portal and other educational tools through our National Resource Center for Health IT promoting consumer knowledge of how to increase safety and quality of care with information technology. AHRQ is engaging with key stakeholders to promote partnership and utilization of AHRQ products supporting the overarching goal. The FY 2008 target is to develop a tool to assess consumer perspectives on the use of EHRs; the results of these efforts are expected in October 2008.

Progress Toward National Health IT Adoption		
Year	**Target**	**Result**
2005	Complete at least two phased EHR improvements that could facilitate transferability to other public/private providers.	Phased improvements of IHS EHR. Discussions with IHS and NASA Health IT
	Summit, "FY 2006 Grant program regarding the utilization of PHR by patients and providers."	Summit held in partnership with the Markle Foundation the Robert Wood Johnson Foundation
2006	Partner with one major HHS Operating Division to expand the capabilities of the EHR.	American Health Information Community (AHIC) Work Group May 2006 recommendation to partner with Centers for Medicare and Medicaid on PHR technology
	The core capabilities and function of the Personal Health Record will be delineated.	AHIC Consumer Empowerment Workgroup 2006
2007	AHRQ will partner with one major HHS Operating Division to expand the capabilities of the EHR.	10/2007
2008	AHRQ will develop a tool to assess consumer perspectives on the use of personal EHRs.	10/2008
		Data Source: AHRQ Administrative Data

5c. Health Information Technology (ONC)

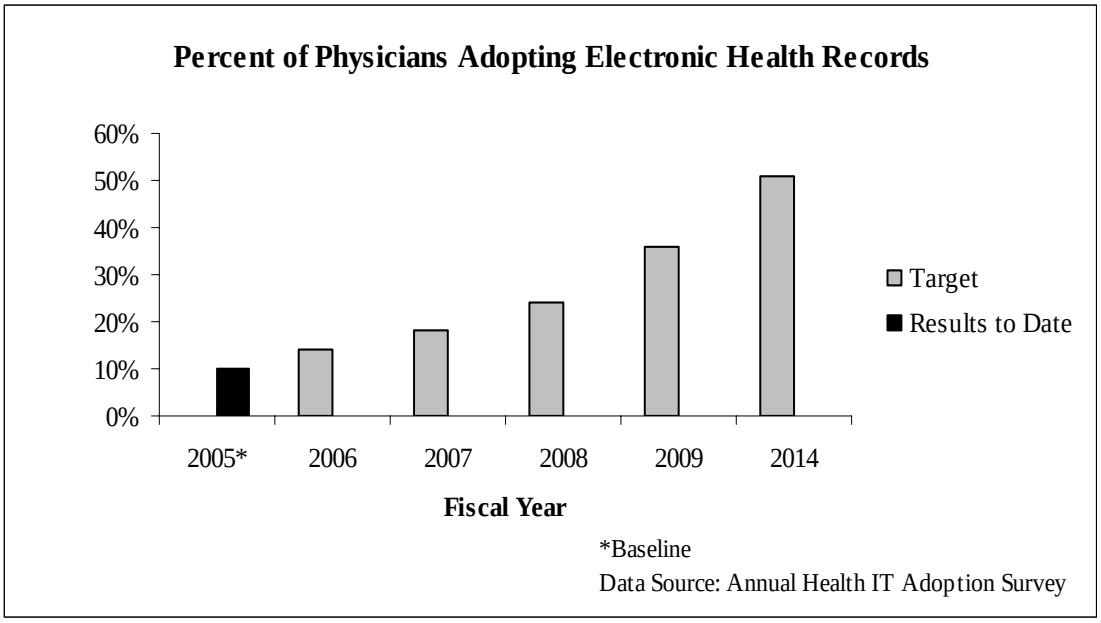
Description: The Office of the National Coordinator for Health Information and Technology (ONC) was created in April 2004 by Presidential Executive Order to address strategic planning, coordination, and analysis related to the public and private adoption of health information technology.

Performance Measure: *Increase physician adoption of Electronic Health Records (EHRs).*

The President called for most Americans to have access to care supported by EHRs by the year 2014. This is a critical component in improving the quality of health care offered to our Nation's citizens. Our current health care system is fragmented in part by the lack of health/medical information that can follow the patient wherever he or she may need to access care. Ensuring that critical health information is "portable" requires that this information be generated, maintained, and transmitted electronically. Without widespread adoption of interoperable EHRs, there is little opportunity for improving the quality of care in our Nation that is dependent upon the portability of clinical information. Realization of this adoption goal will require meeting a number of challenges, including the ability to measure the rate of physician adoption of EHRs in a consistent and timely way. To that end, ONC directed an initiative to develop a standardized adoption measurement methodology which assures that surveys assess physicians who have not only purchased EHRs, but are using the key functions that support safer, more effective health care.

Past Performance and Future Targets

The information available to date indicates that the adoption rate of EHRs among physicians in 2005 was slightly less than 10 percent. The current challenge is to determine and address the multiple barriers that physicians face in transitioning from paper based to electronically-based medical records. ONC anticipates a rate of 18 percent in FY 2007, based on trend analyses of adoption rates of information technologies in other fields. The FY 2008 target is to increase physician adoption of EHRs to 24 percent. FY 2006 data should be available in May 2007.



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 supports targeted efforts to increase the independence and stability of low-income families, people with disabilities, older Americans, Native Americans, victims of domestic violence, refugees, and distressed communities. HHS will also continue to support community and faith-based organizations that provide services to individuals and communities in need.

Two programs are highlighted under this strategic goal including the Administration for Children and Families' (ACF) Temporary Assistance for Needy Families program and the Administration on Aging (AoA) Services Program.

6a. Temporary Assistance for Needy Families (ACF)

Description: The Temporary Assistance for Needy Families (TANF) program, established by Title IV-A of the Social Security Act, provides assistance to needy families; reduces dependency by promoting job readiness, employment, and marriage; prevents and reduces out-of-wedlock pregnancies; and encourages the formation and maintenance of two-parent families.

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

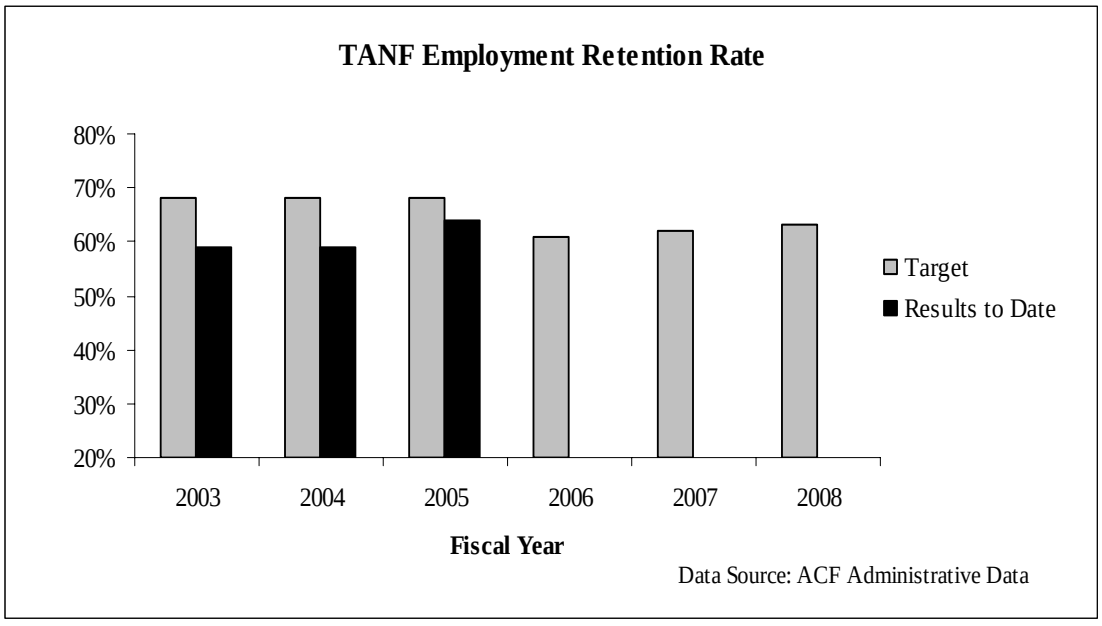
The job retention performance measure supports the purpose of TANF by encouraging employment stability for those most in need, thus improving their economic and social well-being.

Past Performance and Future Targets

The FY 2005 job retention rate was 64.4 percent, missing the 68 percent target. When setting the 68 percent target, ACF did not take into consideration the dampening effect of the caseload reduction credit, which significantly reduced State work participation rate targets and thus reduced State incentive for moving TANF recipients into employment. Between FY 2001 and FY 2005 nearly 60 percent of the adult TANF recipients were not engaged in any work or work preparation activities. New targets for the years following FY 2005, set during the CY 2005 Program Assessment Rating Tool review, were revised downward to reflect these effects.

The TANF reauthorization in the Deficit Reduction Act of 2005 strengthens current work requirements to ensure adult TANF recipients are engaged in work or activities leading to employment. Factors to consider in relation to results include the time it will take to regulate the new work requirements, as well as the time for States to fully implement the new work requirements.

Results for FY 2006 will be available October 2007. The FY 2008 target for the job retention performance measure is 63 percent; results are expected October 2009.



6b. Aging Services Program (AoA)

Description: This program provides home and community-based support to the elderly so that they may lead healthier and more independent lives. Services include meals to elderly individuals in congregate and home settings; transportation to senior centers, medical appointments, and other venues; services to family members who care for the elderly; and health promotion and disease prevention classes such as exercise programs in senior centers.

Performance Measure: *Increase the number of severely disabled clients who receive selected home and community-based services.*

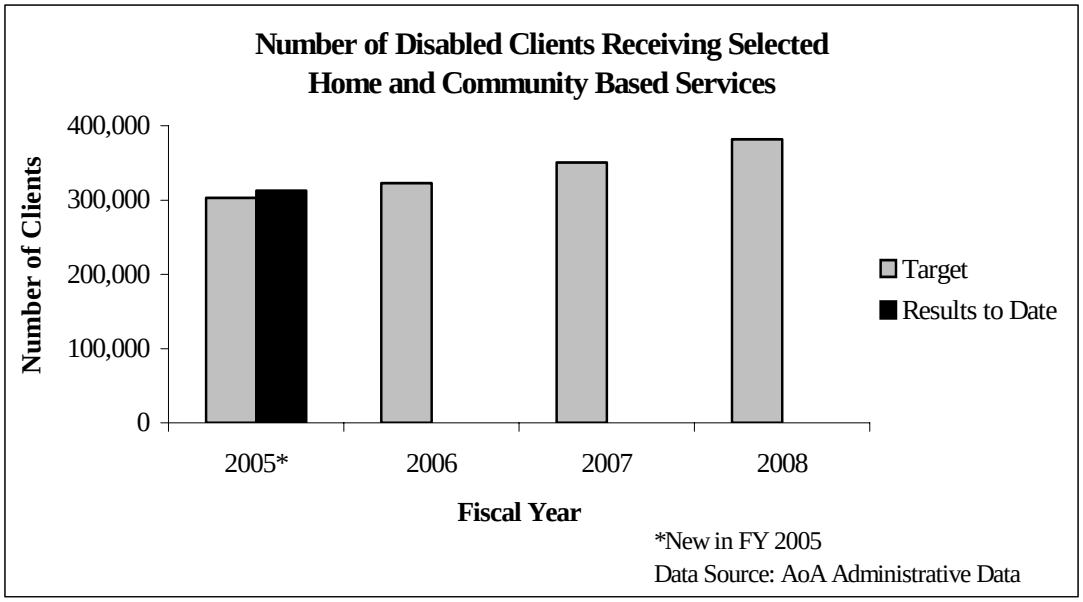
This performance measure directly supports AoA's long term objective of helping elderly individuals to remain in their homes and communities. Severely disabled clients are defined as those with three or more Activities of Daily Living Limitations. These limitations include activities related to personal care, such as bathing or showering, dressing, getting in or out of bed or a chair, using the toilet, and eating. Examples of selected home and community-based services include home-delivered meals, transportation, disease prevention classes, and caregiver support.

This measure complements AoA's efficiency and program quality performance measures. Specifically, grantees are discouraged from channeling resources to the easy-to-serve clients to give the appearance of improved efficiency. Instead grantees are challenged to improve efficiency and client outcomes while serving vulnerable and difficult to serve populations, such as the disabled.

Past Performance and Future Targets

In FY 2005, 313,362 severely disabled clients received selected home and community based services. This exceeded the FY 2005 performance target by over 10,000 and exceeded FY 2004 performance by nearly 20,000.

AoA set aggressive targets in the outyears with a 15 percent increase above the FY 2005 baseline in 2006; 25 percent increase in FY 2007, and a 30 percent increase in FY 2008. The FY 2008 target is to increase the number of severely disabled clients who receive selected home and community-based services to 381,550; results are expected in July 2009.



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 will support programs that increase the involvement and financial support of non-custodial parents; increase the percentage of children and youth living in a safe and stable environment; and continue to support the social and cognitive development of preschool children.

Three programs are highlighted in this report including the Administration for Children and Families' (ACF's) Child Support Enforcement, Child Welfare, and Head Start programs.

7a. Child Support Enforcement (ACF)

Description: The Child Support Enforcement (CSE) program is a joint Federal, State, and local partnership that seeks to ensure financial and emotional support for children from both parents by locating non-custodial parents, establishing paternity, and establishing and enforcing child support orders.

Performance Measure: *Maintain the child support collection rate for current support orders.*

Child support collections play an important role for families transitioning from welfare to self-sufficiency. By securing support from non-custodial parents on a consistent basis, families may avoid the need for public assistance, thus reducing government spending. The child support collection rate is a proxy for the regular and timely payment of support, and directly indicates achievement of the performance target by comparing total dollars collected for current support in Title IV-D cases with total dollars owed for current support in Title IV-D cases.

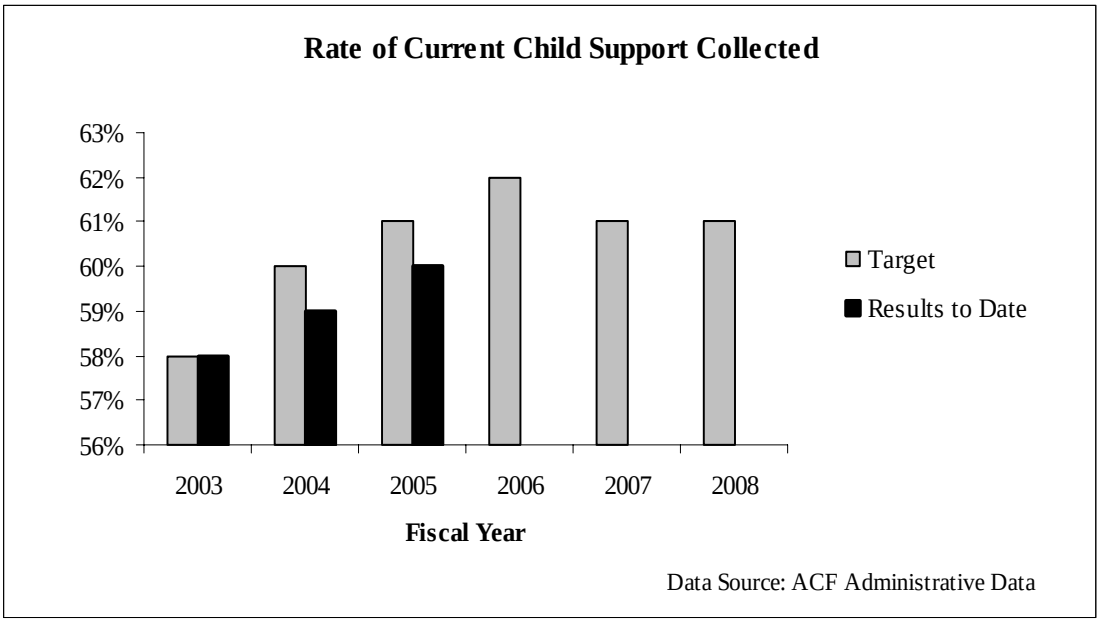
Since the creation of the CSE program, child support collections within the program have grown annually. States have increased collections by using a wide variety of approaches such as income withholding, offset of income tax refunds, and reporting to credit bureaus. In addition, new collection tools and program improvements, such as new hire reporting and increasing statewide automation, have increased collections and reliability of collections data and will continue to do so as these tools become fully implemented in all States.

The Deficit Reduction Act of 2005 (DRA) included a series of provisions to strengthen and improve the CSE program. DRA provisions prioritize collection of medical child support, strengthen existing collection and enforcement tools, reduce unnecessary Federal expenditures, and allow States the option to provide additional support to the families who need it most. Additionally, beginning in FY 2008, the DRA eliminates Federal match for State expenditure of child support incentive payments. This provision is expected to reduce overall program expenditures as well as the rate of growth of collections.

Past Performance and Future Targets

The total amount of child support distributed as current support in FY 2005 was $17.4 billion out of $29.1 billion in total current support assigned to States and due to families in that year. This translates into a current support collection rate of 60 percent, which is a one percentage point increase over the previous year, and one percentage point below the set target of 61 percent.

In developing the targets for FY 2008 performance measures, ACF assumed that overall CSE expenditures will decrease as a result of DRA provisions, such as the elimination of Federal match on State expenditure of incentive payments. ACF expects that this will result in current support collections increasing at a decreasing rate compared to pre-DRA levels, and accordingly adjusted targets downward. The FY 2007 and FY 2008 targets are now 61 percent; results are expected September 2008 and 2009, respectively.


Rate of Current Child Support Collected
63%
62%
61%
60%
59%
58%
57%
56%
2003
2004
2005
2006
2007
2008
Fiscal Year
Target
Results to Date
Data Source: ACF Administrative Data

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

Description: Child Welfare programs prevent maltreatment of children, provide in-home services for at-risk children and families, find temporary foster placements for children who must be removed from their homes, and achieve safe and stable permanent placements for children. Foster Care helps States provide care for children who need to live apart from their families due to risk of abuse, by placing them in a foster family home or an institution. It provides States with funding for foster care payments; administrative costs; and training for staff, foster parents, and others. Adoption programs strive to eliminate barriers to adoption; promote recruitment of adoptive parents; provide financial incentives to encourage adoption; and develop adoption assistance agreements with parents who adopt children with special needs.

Performance Measure: *Increase the adoption rate.*

The adoption rate measures the effectiveness of Federal child welfare and adoption programs. In order to measure program performance more accurately, ACF has replaced a prior measure of total adoptions with an adoption rate calculated as the annual number of adoptions divided by the number of children in foster care at the end of the prior year.

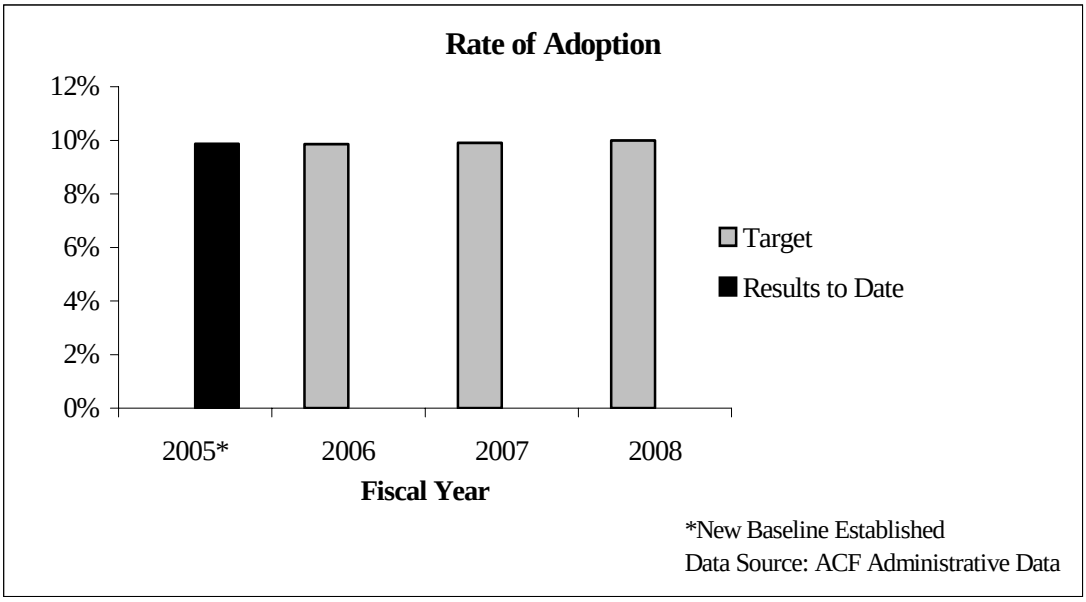
While the annual number of adoptions continues at a historically high level of over 50,000 (as compared to the 26,000 adoptions reported in FY 1995), since FY 2002, the annual number of adoptions has leveled off. The adoption rate measure, developed through the Program Assessment Rating Tool process, better accounts for the dynamics of the foster care caseload and the number of children within foster care for whom adoption has been identified as the appropriate permanency plan. This change to an adoption rate measure is particularly salient since the total number of children in foster care has declined from 567,000 in FY 1999 to 513,000 in FY 2005. In addition to the decrease in the foster care population other trends continue to make it more challenging to increase adoptive placements, including the fact that the age of children "waiting" to be adopted continues to increase. Almost half of the "waiting" children are over the age of nine. Simultaneously, the proportion of children in foster care with a case plan goal of adoption has declined.

Past Performance and Future Targets

Preliminary data indicate that there were 51,000 adoptions in FY 2005, although this number is likely to increase as additional adoptions for FY 2005 are reported.[1] At its current FY 2005 rate of adoptions (9.86 percent), the program appears to be on track to meet its FY 2006 target rate. The gradual increase in the adoption rate to 10 percent by FY 2008 is ambitious, but also realistic due to the aging of the foster care population, the decline in the number of children in foster care, and the decrease in the proportion of children with a goal of adoption.

Results for FY 2006 will be available October 2007. The FY 2008 target for the adoption rate is 10 percent; results are expected October 2009.

[1] Adoption and Foster Care Analysis and Reporting System (AFCARS) permits the reporting of adoptions finalized in one year to be reported in later years. The current FY 2005 number of adoptions is 51,000. Based on previous experience, it is likely, with new AFCARS adoptions submissions and resubmissions from the States, that the number of adoptions finalized in FY 2005 will increase by as many as 2,000 adoptions.


Rate of Adoption
12%
10%
8%
6%
4%
2%
0%
2005*
2006
2007
2008
Fiscal Year
Target
Results to Date
*New Baseline Established
Data Source: ACF Administrative Data

7c. Head Start (ACF)

Description: Head Start is a comprehensive child development program that serves children under five, pregnant women, and their families. Its goal is to increase the school readiness of young children in low-income families.

Performance Measures:

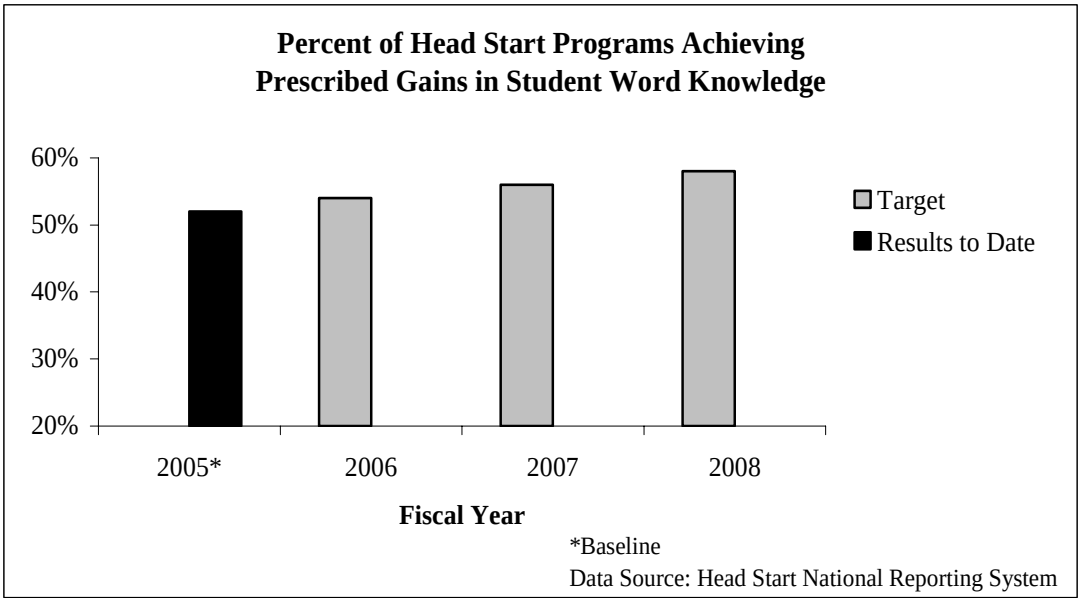
1 *- Increase the percentage of Head Start programs that achieve average fall to spring gains of at least 12 months in word knowledge (as measured by the Peabody Picture Vocabulary Test) in the National Reporting System.*

2 *- Increase the percentage of Head Start programs that achieve average fall to spring gains of at least four counting items.*

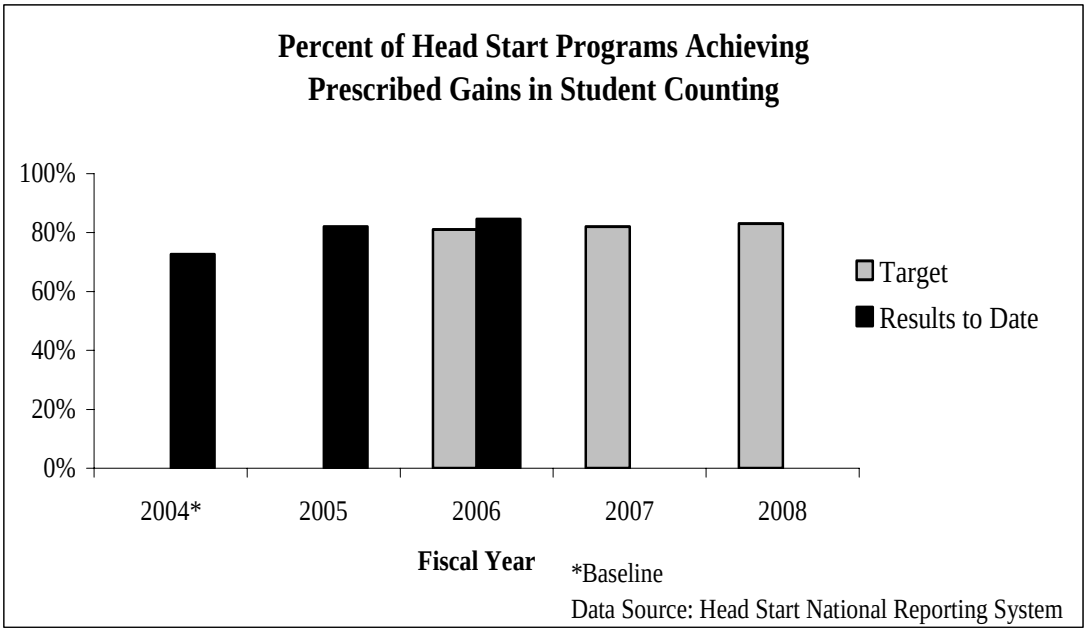
These Head Start performance measures capture the progress of individual Head Start grantees in improving children's word knowledge and early numeracy skills. These skills have been shown to predict improved academic performance in school and are the precursors to learning to read, write, and do arithmetic.

Past Performance and Future Targets

As displayed in the graph below, in FY 2005, Head Start programs established a new baseline for the word knowledge measure, with 52 percent achieving the prescribed gains. Annual improvements of two percentage points are scheduled for FY 2006 through FY 2008. The FY 2008 performance target is for 58 percent of programs to achieve the prescribed gains; results are expected in December 2008.



As displayed in the graph below, in FY 2006, 85 percent of Head Start programs achieved the prescribed gains for counting items. This performance exceeded the target of 81 percent and is 12 percentage points higher than the performance from two years prior. In FY 2007 and FY 2008, this high level of performance will be maintained; results for FY 2008 are expected in December 2008.



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 has a citizen-based focus, is results oriented, and is market-driven, where practicable. The Centers for Medicare & Medicaid Services' (CMS) Medicare Integrity Program is highlighted in this section. Program integrity efforts ensure the Medicare program pays the right amount to legitimate providers for covered, reasonable, and necessary services that are provided to eligible beneficiaries.

8a. Medicare Integrity Program (CMS)

Description: The Medicare Integrity Program (MIP) is the primary CMS program for safeguarding the Medicare Trust Funds against fraud, waste and abuse. MIP conducts reviews and investigations of Medicare expenditures to ensure Trust Fund resources are utilized properly for Medicare's mission.

Performance Measure: *Reduce the percentage of improper payments made under the Medicare Fee-for-Service Program.*

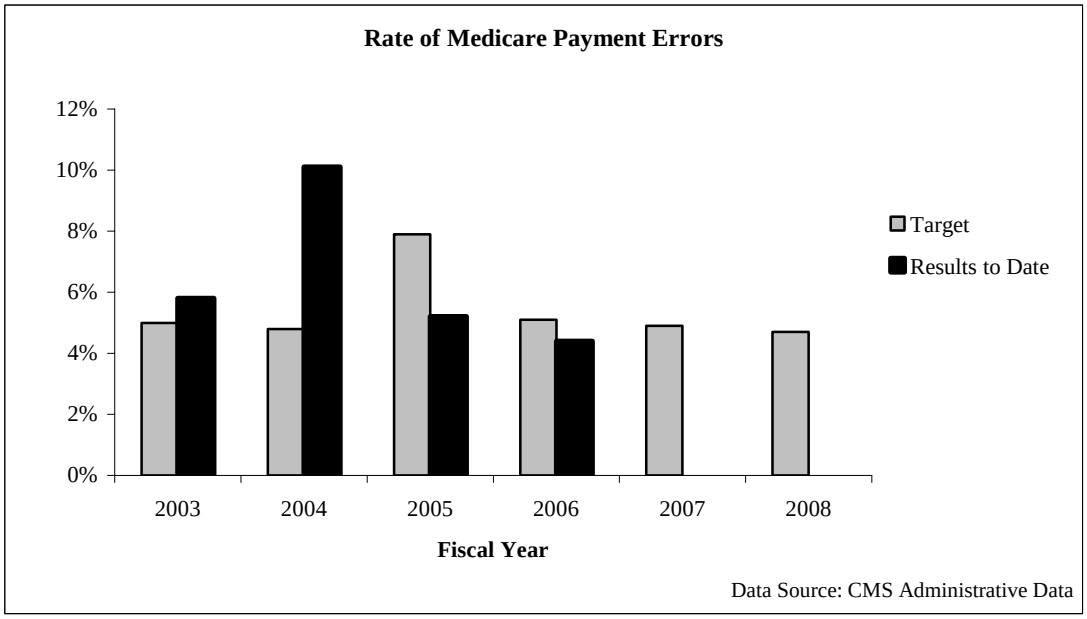
One of the major goals for CMS is to pay claims properly the first time. Paying providers appropriately the first time saves resources and ensures the proper payment of limited Medicare Trust Fund dollars. During the CY 2002 Program Assessment Rating Tool process, CMS set ambitious annual targets for reducing the Medicare error rate for FY 2004 and beyond.

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 to minimize these vulnerabilities and reduce the Medicare claims payment error rate. The Comprehensive Error Rate Testing (CERT) program was initiated in FY 2003 and has produced a national error rate for each year since its inception.

Past Performance and Future Targets

Error rate information for years preceding the FY 2003 report was compiled by the Office of Inspector General (OIG). CMS assumed responsibility for measuring the error rate beginning in FY 2003 with oversight by the OIG. The graph below displays targets and results from FY 2003 through FY 2008. The target increases between FY 2004 and FY 2005 because of the transition to the CMS CERT program.

CMS exceeded the FY 2006 error rate target of 5.1 percent with a lower error rate of 4.4 percent. Therefore, CMS adjusted its error rate targets downward for future years. Results for FY 2007 will be available November 2007. The FY 2008 target for the improper payments rate is 4.2 percent; results are expected November 2008.



HHS PARTED PROGRAMS

	PART Cycle	Narrative Rating
Food and Drug Administration:		
Overall	CY 2003	Moderately Effective
Health Resources and Services Administration:		
Health Centers	CY 2002	Effective
Health Professions	CY 2002	Ineffective
Maternal and Child Health Block Grant	CY 2002	Moderately Effective
National Health Service Corps	CY 2002	Moderately Effective
Nursing Education Loan Repayment and Scholarship	CY 2002	Adequate
Ryan White	CY 2002	Adequate
Children's Hospital Graduate Medical Education Program	CY 2003	Adequate
Rural Health Activities	CY 2003	Adequate
Emergency Medical Services for Children	CY 2004	RND
National Bone Marrow Donor Registry	CY 2004	Moderately Effective
Organ Transplantation	CY 2004	Adequate
Poison Control Centers	CY 2004	Adequate
Traumatic Brain Injury	CY 2004	RND
Family Planning	CY 2005	Moderately Effective
Health Care Facilities Construction	CY 2005	RND
Healthy Community Access Program	CY 2005	Ineffective
State Planning Grant Program - Uninsured	CY 2005	Ineffective
Trauma/Emergency Medical Services	CY 2005	Adequate
Universal Newborn Hearing Screening	CY 2005	Moderately Effective
Black Lung Clinics	CY 2006	Ineffective
Free Clinics Medical Malpractice Coverage	CY 2006	Adequate
Hansen's Disease Services Program	CY 2006	Moderately Effective
Healthy Start	CY 2006	Moderately Effective
National Practitioner/Health Integrity Data Banks	CY 2006	Effective
Radiation Exposure Screening and Education Program	CY 2006	Ineffective
Telehealth	CY 2006	Moderately Effective
Indian Health Service:		
Federally Administered Activities	CY 2002	Moderately Effective
Sanitation Facilities Construction	CY 2002	Moderately Effective
Resource and Patient Management System	CY 2003	Effective
Urban Health	CY 2003	Adequate
Health Facilities Construction	CY 2004	Effective
Tribally Operated Health Programs	CY 2005	Adequate
Centers for Disease Control and Prevention:		
317 Immunization Program	CY 2002	Adequate
Breast and Cervical Cancer	CY 2002	Adequate
Diabetes	CY 2002	Adequate
Domestic HIV/AIDS Prevention	CY 2002	RND
Agency for Toxic Substances and Disease Registry	CY 2003	Adequate
State/Local Public Preparedness	CY 2003	RND
Buildings and Facilities	CY 2004	Adequate
Infectious Diseases	CY 2004	Adequate
Occupational Safety and Health	CY 2004	Adequate
Sexually Transmitted Diseases / Tuberculosis	CY 2004	Adequate
Environmental Health	CY 2005	Adequate

	PART Cycle	Narrative Rating
Global Immunizations	CY 2005	Effective
Health Statistics	CY 2005	Moderately Effective
Strategic National Stockpile	CY 2005	Moderately Effective
Birth Defects and Developmental Disabilities	CY 2006	Moderately Effective
Chronic Disease Prevention	CY 2006	Moderately Effective
Injury Prevention and Control	CY 2006	Moderately Effective
Terrorism: Intramural Activities	CY 2006	RND
Terrorism: Biosurveillance	CY 2006	RND
National Institutes of Health:		
HIV / AIDS Research	CY 2003	Moderately Effective
Extramural Research Activities	CY 2004	Effective
Buildings and Facilities	CY 2005	Effective
Intramural Research	CY 2005	Effective
Extramural Construction	CY 2006	Moderately Effective
Extramural Research Training and Research Career Development	CY 2006	Effective
Substance Abuse and Mental Health Services Administration:		
Children's Mental Health Services	CY 2002	Moderately Effective
Projects for Assistance in Transition from Homelessness	CY 2002	Moderately Effective
Substance Abuse Treatment Program of Regional & National Significance.	CY 2002	Adequate
Mental Health Block Grant	CY 2003	Adequate
Substance Abuse Prevention & Treatment Block Grant	CY 2003	Ineffective
Substance Abuse Prevention Project of Regional & National Significance.	CY 2004	Moderately Effective
Mental Health Programs of Regional & National Significance.	CY 2005	RND
Protection and Advocacy for Individuals with Mental Illness	CY 2005	Moderately Effective
Agency for Healthcare Research and Quality:		
Data Collection and Dissemination	CY 2002	Moderately Effective
Patient Safety	CY 2003	Adequate
Pharmaceutical Outcomes	CY 2004	Moderately Effective
Centers for Medicare & Medicaid Services:		
Medicare Integrity Program	CY 2002	Effective
Medicare Program	CY 2003	Moderately Effective
SCHIP	CY 2003	Adequate
Medicaid	CY 2006	Adequate
Administration for Children and Families:		
Refugee and Entrant Assistance: Targeted Assistance & Social Services.	CY 2002	Adequate
Child Support Enforcement	CY 2003	Effective
Community Services Block Grant	CY 2003	RND
Developmental Disabilities	CY 2003	Adequate
Foster Care	CY 2003	Adequate
LIHEAP	CY 2003	RND
Assets for Independence	CY 2004	Adequate
Child Care	CY 2004	Moderately Effective
Child Welfare: Child Abuse Prevention & Treatment Act State Grants	CY 2004	RND
Child Welfare: Community-Based Child Abuse Prevention	CY 2004	RND
Child Welfare: Independent Living	CY 2004	RND
Violent Crime Reduction Programs	CY 2004	RND
Adoption Assistance	CY 2005	Moderately Effective
Adoption Incentives	CY 2005	Adequate
Adoption Opportunities	CY 2005	Adequate
Mentoring Children of Prisoners	CY 2005	RND
Refugee and Entrant Assistance: Transition & Medical Services	CY 2005	Effective

	PART Cycle	Narrative Rating
Social Services Block Grant	CY 2005	RND
Temporary Assistance for Needy Families	CY 2005	Moderately Effective
Victims of Trafficking	CY 2005	Moderately Effective
Abstinence Education	CY 2006	Adequate
Child Welfare Services	CY 2006	Moderately Effective
Compassion Capital Fund	CY 2006	RND
Head Start	CY 2006	Moderately Effective
Promoting Safe and Stable Families	CY 2006	Moderately Effective
Runaway and Homeless Youth	CY 2006	Effective
Unaccompanied Alien Children	CY 2006	Adequate
Administration on Aging:		
Overall	CY 2003	Moderately Effective
Office of the Secretary:		
Bioterrorism Hospital Preparedness	CY 2003	RND
Adolescent and Family Life	CY 2004	RND
Women's Health	CY 2004	RND
Office of Disease Prevention and Health Promotion	CY 2005	RND
Office of Minority Health	CY 2005	RND
OGHA: Afghanistan Health Initiative	CY 2005	RND
OGHA: US Mexico Border Health Commission	CY 2005	RND
Commissioned Corps: Readiness and Response Program	CY 2006	Adequate
Office of the National Coordinator for Health Information Technology	CY 2006	RND
Office of Medicare Hearings and Appeals	CY 2006	RND
Office for Civil Rights		
Office for Civil Rights	CY 2005	Moderately Effective
Office of Inspector General:		
Health Care Fraud and Abuse Control	CY 2002	RND
Multi-Agency PARTs		
CDC/ Department of State/United States Agency for International Development		
President's Emergency Plan for AIDS Relief		
Other Bilateral Programs	CY 2005	Adequate
Focus Countries	CY 2005	Moderately Effective
HRSA/Department of Justice		
Vaccine Injury Compensation	CY 2005	Adequate