Department of Health and Human Services

Fiscal Year 2008

Citizens' Report

Summary of Performance and Financial Results

Message from the Secretary

The Department of Health and Human Services' Mission

The mission of the Department of Health and Human Services is to enhance the health and well-being of Americans by providing for effective health and human services and by fostering strong, sustained advances in the sciences, underlying medicine, public health, and social services.

During FY 2008, the Department of Health and Human Services (HHS) continued to fulfill its charge to protect the health of all Americans and provide essential human services, especially for those who are least able to help themselves. This *Citizens' Report* presents a summary of key past and planned performance of the Department. In keeping with our Strategic Plan (http://aspe.hhs.gov/hhsplan/2007), HHS is making strides in four key areas:

1. *Health Care*: While the majority of Americans get their health care coverage through their workplace or from public programs like Medicare, Medicaid and the State Children's Health Insurance Program (SCHIP), improving access for the forty-five million Americans currently without health insurance presents a large challenge. In the last year reported, the Health Resources and Services Administration (HRSA) funded 337 new or significantly expanded health care sites. Currently more than 7,000 service delivery sites nationwide provide care to an estimated 16.1 million patients with insufficient access to care. The Centers for Medicare and Medicaid (CMS) is also striving to improve the quality of patient care by releasing ratings of Medicare and Medicaid-certified nursing homes. Nursing homes can be compared online at http://www.medicare.gov/NHCompare.

2. *Public Health*: HHS prevention efforts are an important component of public health protection. For example, food-borne illnesses are a substantial health risk in the United States, with surveillance data indicating that each year 76 million Americans suffer illness from food they consume. To help improve food safety and prevent food-borne illnesses, the Food and Drug Administration (FDA) has established offices in areas such as China that export food and other FDA-regulated products to our country.

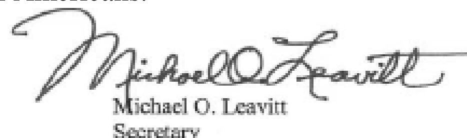
3. *Human Services*: The economic and social well-being of all Americans continues to be a major issue of concern, especially given the current downturn in the economy. The HHS Temporary Assistance for Needy Families (TANF) program not only assists individuals in times of need, it helps to return those individuals to working status. Most recently, 36 percent of TANF recipients became newly employed.

4. *Scientific Research and Development*: Basic science is the foundation for improved health and humans services. The continuum from basic to applied research to practice is a significant emphasis of our scientific research and development enterprise. HHS conducts research and development activities. For example, the National Institutes for Health (NIH) has been working to create new treatments for Type 2 diabetes and chronic kidney disease though randomized clinical trials. In FY 2008, NIH reviewed and evaluated the raw data from the study's indicators and has made a determination that the science is progressing appropriately and should continue.

HHS has continued to make significant progress toward ensuring that reliable and timely information is available for decision-makers. For the tenth consecutive year, HHS earned an unqualified or "clean" audit opinion from our independent Ernst & Young LLC accountants on the Department's consolidated financial statements. The Annual Financial Report (AFR) contains more information on our financial condition (http://www.hhs.gov/afr).

The financial and performance data presented in this report is reliable, complete, and provides the latest data available, except where otherwise noted, and demonstrates the Department's commitment to ensuring the highest measure of accountability to the American people. The data contains no material weaknesses. Additional performance information can be found in the agencies' Annual Performance Reports (APR) found at http://www.hhs.gov/budget/docbudget.htm.

HHS's accomplishments would not have been possible without the dedication and commitment of its employees and partners. They should be proud of the positive impact their contributions have on the lives of Americans. Together, we will continue to strive to enhance the health and well-being of all Americans.



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Contact Information

Performance Improvement Officer
200 Independence Avenue SW
Washington, DC 20201
(202) 690-6151

Snapshot

Department of Health and Human Services Budget, Performance, and Financial Snapshot Fiscal Year 2008

The original version of the Snapshot is part of the "2008 Performance Report of the Federal Government" and can be found at: http://www.whitehouse.gov/omb/expectmore/2008Performance.pdf.

Who Are We

Mission: The Department of Health and Human Services' mission is 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. The Department's Strategic Plan is available at: http://aspe.hhs.gov/hhsplan/2007/.

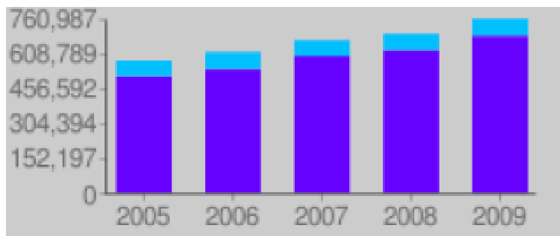
Organization: The Department's mission is carried out by eleven operating divisions. Fifteen staff divisions within the Office of the Secretary provide leadership, direction, and policy and management guidance to the Department. The Department's Organizational Chart is available at http://www.hhs.gov/about/orgchart/.

Personnel: The Department employs over 64,000 individuals who carry out the Department's mission. More than half of the Department's workforce (52%) are employed in scientific, medical, or public health positions.

Budgetary Resources: The budgetary resources for FY 2008 totaled about $700 billion, or given the U.S. population of approximately 302 million people, an average of $2,315 per person.

Budget Snapshot

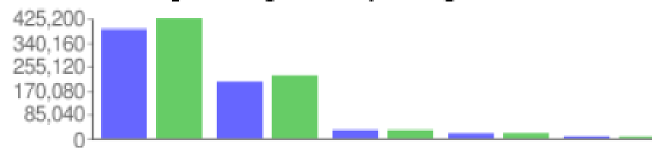
Total Spending FY 2005-2009



	2005	2006	2007	2008	2009
Mandatory	$510,103	$541,532	$597,907	$624,539	$687,539
Discretionary	$68,188	$73,051	$69,160	$70,559	$73,448
Total	$578,291	$614,583	$667,067	$695,098	$760,987

$ in millions

Top 5 Programs By Budget



	Medicare	Medicaid	National Institutes of Health (All Programs)	Temporary Assistance for Needy Families (TANF)	State Children's Health Insurance Program (SCHIP)
2008	$387,400	$201,426	$29,162	$17,532	$6,900
2009	$425,200	$223,755	$29,307	$18,632	$5,946

$ in millions

FY 2008 FY 2009

Performance Snapshot

Accomplishments: The Department is striving to expand of health care access to low-income, underserved, and medically vulnerable populations; since 2001 an additional 5.8 million patients have been treated at HHS-funded Health Centers. HHS is also encouraging the adoption of Electronic Health Records (EHR) with efforts such as a CMS demonstration project aimed at encouraging 1,200 small to medium-sized physician practices to adopt EHRs. HHS has also made significant progress in developing cell-based influenza vaccines.

Challenges: The scale, scope, and complexity of the Department's activities results in a number of management challenges, including: oversight of Medicare Part D and Medicare Advantage; integrity of Medicare payments; appropriateness of Medicaid and State Children's Health Insurance Program payments; quality of care; public health and medical emergency preparedness; oversight of food, drug, and medical device safety; grants management; integrity of information technology systems and the implementation of health information technology; and ethics program oversight and enforcement. More detailed information on these challenges is available at: http://www.oig.hhs.gov/publications/challenges.asp.

Financial Snapshot

Clean Opinion on Financial Statements			**Yes**
Timely Financial Reporting	Yes	Material Weaknesses	2
Improper Payment Rate	6.9%	Total Assets	$529,300
Total Liabilities	$86,600	Net Cost of Operations	$709,100

$ in millions

Footnote: In the "Budget Snapshot" bar charts, "discretionary" amounts are budget authority, and "mandatory" amounts are outlays. Amounts for FYs 2005-2008 are actuals; amounts for FY 2009 are annualized FY 2009 Continuing Resolution funding levels for discretionary budget authority (after a transfer to the Social Security Administration's Limitation on Administrative Expenses account) and baseline estimates for mandatory outlays. Amounts for the National Institutes of Health (NIH) are budget authority, and amounts for Medicare, Medicaid, TANF, and SCHIP are outlays. TANF amounts do not include outlays from the contingency fund (which were $348 million in FY 2008, and $1.219 billion in FY 2009). NIH amount for FY 2008 reflects a transfer of $295 million to the Global Fund to Fight HIV/AIDS, Tuberculosis, and Malaria. The improper payment rate represents a Department-wide average.

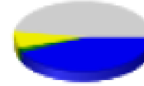
FY 2008 Performance Results per Strategic Goal

Met/Exceeded | Not met but improved over prior years | Not met target | Data not yet available

Budget per Strategic Goal ($ in millions)

Strategic Goal One: Health Care

Improve the safety, quality, affordability, and accessibility of health care, including behavioral health care and long-term care.

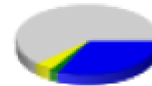


2008 Actual = $619,303

Performance Measure(s)*	2006 Results	2007 Results	2008 Target	2008 Results	2009 Target
Increase the number of States that have the ability to assess improvements in access and quality of health care through implementation of the Medicaid Quality Improvement Program.	N/A	0	8	8	9
Reduce the percentage of improper payments made under the Medicare fee-for-service (FFS) programs.	4.4%	3.9%	3.8%	3.6%	3.5%
Implement the Medicare Prescription Drug Benefit – Increase the percentage of Medicare beneficiaries with prescription drug coverage from Part D or other sources.	N/A	90%	N/A	90%	91%

Strategic Goal Two: Public Health Promotion and Protection, Disease Prevention, and Emergency Preparedness

Prevent and control disease, injury, illness, and disability across the lifespan, and protect the public from occupational, environmental and terrorist threats.

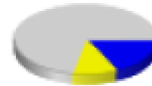


2008 Actual = $8,013

Performance Measure(s)*	2006 Results	2007 Results	2008 Target	2008 Results	2009 Target
Reduce complications of diabetes by increasing the proportion of American Indian/Alaska Native patients with diagnosed diabetes that have achieved blood pressure control (<130/80).	38%	38%	38%	35%	38%
Reduce fatal work-related injuries among youth ages 15 to 17.	3.2/100,000 FTE	2.0/100,000 FTE	2.5/100,000 FTE	2.0/100,000 FTE	3.0/100,000 FTE

Strategic Goal Three: Human Services

Protect the economic and social well-being of individuals, families, and communities.

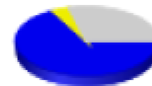


2008 Actual = $44,612

Performance Measure(s)*	2006 Results	2007 Results	2008 Target	2008 Results	2009 Target
Increase the adoption rate for children involved in the Child Welfare System.	9.91%	10.00%	10.00%	Oct. 2009	10.10%

Strategic Goal Four: Scientific Research and Development

Advance scientific and biomedical research and development related to health and human services.



2008 Actual = $27,243

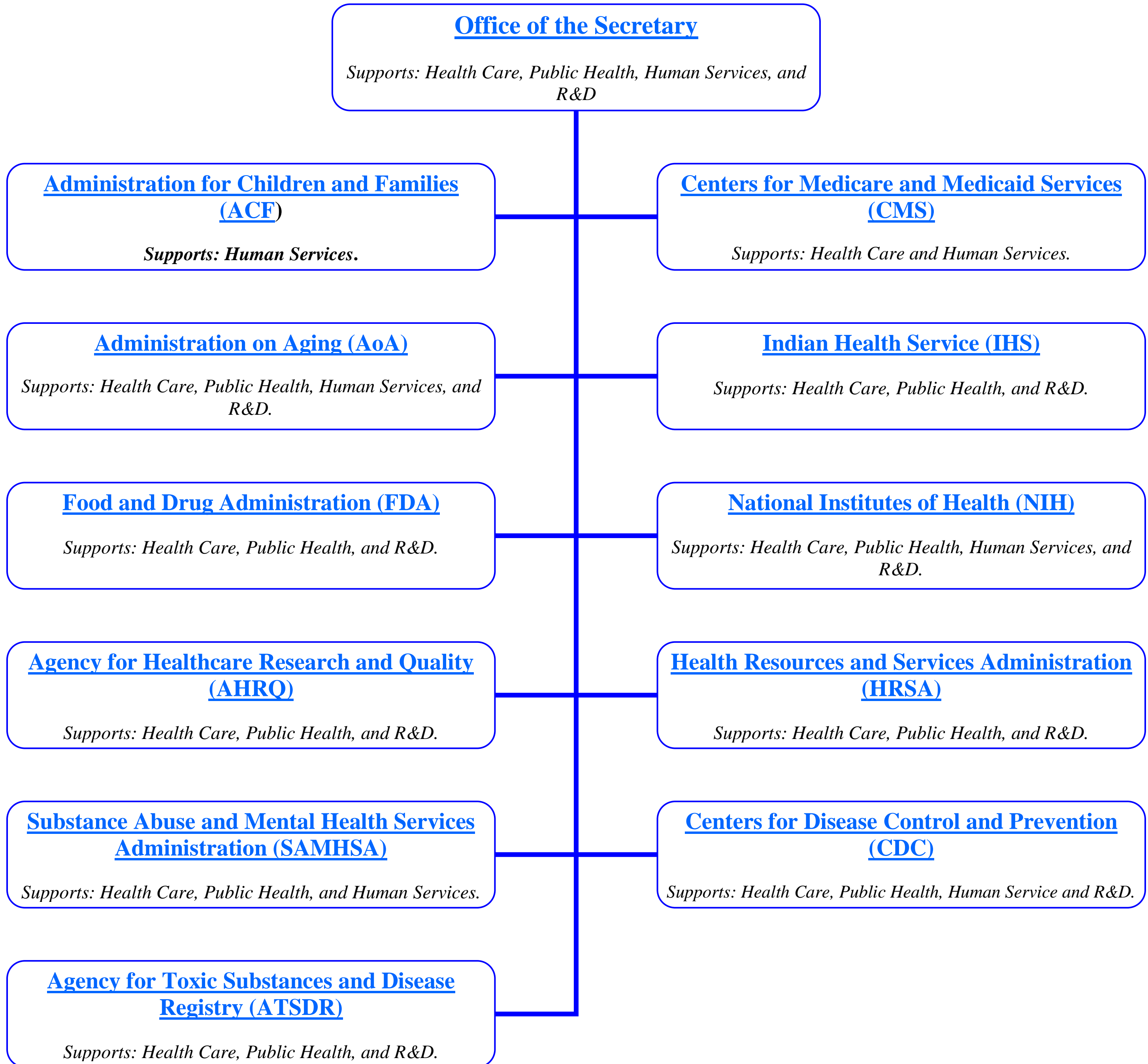
Performance Measure(s)*	2006 Results	2007 Results	2008 Target	2008 Results	2009 Target
Through the National Research Service Award Program, increase the probability that scientists continue participation in NIH-funded research within the following 10 years (Postdoctoral Fellows).	13%	13%	12%	13%	12%
Reduce the financial cost (or burden) of upper gastrointestinal (GI) hospital admissions by implementing known research findings, as measured by per capita charges for GI bleeding.	$93.36	$91.81	$91.71	$87.10	$90.75

*This measure was selected from a number of performance measures aimed at the specific strategic goal.

HHS Organization Chart and Agencies by Strategic Goal

The Secretary leads a Department that provides a wide range of services and benefits to the American people. Below is an organizational chart that shows both the Department structure and how these areas link to the HHS Strategic Plan. Further details concerning each major Departmental agency's role in accomplishing the overall mission and strategic goals are discussed in the HHS Strategic Plan (http://aspe.hhs.gov/hhsplan/2007/).

The organizational chart below shows how each HHS Operating Division supports the four HHS Strategic Goals:
Goal One: Health Care
Goal Two: Public Health Promotion and Protection, Disease Prevention, and Emergency Preparedness ("Public Health")
Goal Three: Human Services
Goal Four: Scientific Research and Development ("R&D")



Overview of Department Performance

Through its eleven Operating Divisions and fifteen Staff Divisions, HHS implements over 300 programs affecting the health, safety, and welfare of every American. Detailed information about each HHS program and their associated performance measures can be found at: www.hhs.gov/budget/docbudget.htm.

Forty measures from throughout HHS are included in the Strategic Plan, these measures are selected because they represent the major contributors to the Department's strategic goals. These measures, and related successes and challenges, are discussed in the following pages organized by Strategic Goal and Objective. For more information about any of the programs covered in this document, please see the respective HHS agency website link available at www.hhs.gov/about/index.html.

The success of HHS' programs is gauged through the hundreds performance measures that the Department tracks. While this document reports on FY 2008 performance, HHS does not yet have this year's data for some programs' measures due to data lag. HHS is often challenged with data lag associated with its measures since many programs operate through grants that are directly managed by various organizations and State governments. The table below shows HHS' overall progress in meeting its more than 1,030 performance measures. For FY 2008, only 40 percent of HHS' performance measures are currently able to report data. Of these, 84 percent met or exceeded their targets. As actual results for measures are reported, HHS continues to meet a large percentage of its targets, which is notable considering the size and scope of the Department. For example, with 85 percent of measures reporting data in FY 2007, HHS met an impressive 72 percent of performance targets for that year. In the pages that follow, HHS has provided the most recent data available for each measure, including its targets and results. Some measures are newly developed and may lack established baselines or annual targets. In these cases, we have reported available results. In other cases, HHS has reported historical data for newly established measures in order to place these results in context. Where appropriate, an explanation is provided for the missing data and/or targets.

Summary of Performance Targets and Results

Fiscal Year	Total Targets	Targets with Results Reported	Percent of Targets with Results Reported	Total Targets Met	Percent of Targets Met
2005	745	733	98%	544	74%
2006	828	790	95%	580	73%
2007	929	794	85%	574	72%
2008	1030	404	40%	338	84%

Strategic Goal One: Health Care

Improve the safety, quality, affordability, and accessibility of health care including behavioral health care and long-term care.

The four broad objectives under *Health Care* are:

- Objective 1.1: Broaden health insurance and long-term care coverage;
- Objective 1.2: Increase health care services availability and accessibility;
- Objective 1.3: Improve health care quality, safety, cost, and value; and
- Objective 1.4: Recruit, develop, and retain a competent health care workforce.

Today, disease, illness, and disability can be as much of a threat to Americans' financial well-being as they are to Americans' physical and mental well-being. Medicaid and Medicare health care spending in America is projected to increase from four percent of Gross Domestic Product (GDP) in 2009 to more than 12 percent by 2050.[1] This increase is expected because of the rising costs per person rather than the aging of the population. Already Americans continue to spend an increasing share of their income on health care. Health care has to be available, affordable, portable, transparent, and efficient. Improving quality, constraining costs, and providing greater access remain key priorities. HHS strives to increase the rate at which patients receive recommended services and to reduce the number of unnecessary services. The Department is also focusing on eliminating preventable medical errors.

Strategic Goal One Success Story: Medicaid Quality Improvement Program

Although State participation is voluntary, the Centers for Medicare and Medicaid Services (CMS) has received enthusiastic support from States and other stakeholders to collaborate in the long-term measure to improve quality in the Medicaid program. The measure currently tracks the number of States participating in the Medicaid Quality Improvement Program, which creates a framework and supports States in achieving safe, effective, efficient, timely, equitable, and patient-centered care. In FY 2008, CMS distributed eight State-specific, comprehensive Quality Assessment Reports as the first steps to developing a National Medicaid Quality Framework. CMS anticipates completing a report for all State Medicaid programs. By achieving long-term quality targets, CMS will improve care for all Medicaid beneficiaries.

The increasing burden of health spending on the U.S. economy is unsustainable. Higher spending on public programs such as Medicare and Medicaid strain Federal and State budgets. Higher insurance premiums burden workers with higher health costs and pose a challenge to employers. Additionally, 45 million Americans do not have health insurance.[2] These individuals may face barriers to obtaining timely and continuous care. Because of their limited access to the system, their health problems may become more severe.

HHS Strategic Goal 1 targets the need for people to be able to obtain and maintain affordable health care coverage; receive efficient, high-quality health care services; and access appropriate information for informed choices. Since 2002, the HHS Health Centers Program has increased access and the number of patients served, reaching over 16.1 million patients in 2007. The program is estimated to serve 16.7 million patients in FY 2008 and 17.05 million in FY 2009.

The table below shows HHS' progress in meeting all the performance measures among the 40 measures in the Strategic Plan related to Strategic Goal 1.

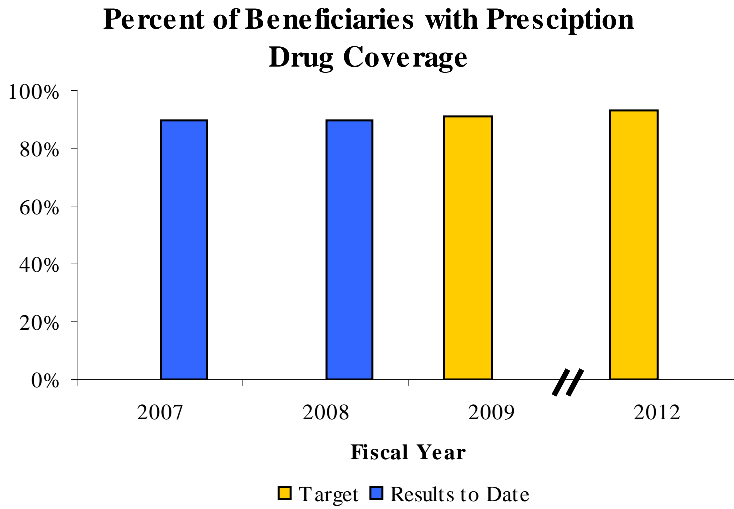
Fiscal Year	Total Targets	Targets with Results Reported	Percent of Targets with Results Reported	Total Targets Met	Percent of Targets Met
2005	6	6	100%	4	67%
2006	7	7	100%	6	86%
2007	9	7	78%	6	86%
2008	11	6	55%	6	100%

[1] Congressional Budget Office. (2008). *Key Issues in Analyzing Major Health Insurance Proposals* . Available at http://www.cbo.gov/ftpdocs/99xx/doc9924/12-18-KeyIssues.pdf

[2] United States Census Bureau, Housing and Household Economic Statistics Division (2008). *Income, Poverty, and Health Insurance Coverage in the United States: 2007".* Available at http://www.census.gov/hhes/www/hlthins/hlthin07.html.

Strategic Objective 1.1: Broaden health insurance and long-term care coverage.

Measure Spotlight: Implement the Medicare Prescription Drug Benefit – Increase the percentage of Medicare beneficiaries with prescription drug coverage from Part D or other sources.



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

Performance: Following the introduction of the Medicare Part D program in 2006, approximately 90 percent of Medicare beneficiaries had prescription drug coverage from Part D or other sources. Given the initial success of the program, enrollment rate improvements are likely to slow down somewhat because remaining non-enrollees are those who are very hard to reach or who have made a choice not to enroll. The Centers for Medicare and Medicaid Services (CMS) continues to take steps to educate, inform, and protect beneficiaries. Such steps include: making information available at www.medicare.gov, where beneficiaries can review and compare all of the health and prescription plans available in their area; and ensuring that people who do not have computer access can get the same information 24 hours a day, 7 days a week at 1-800-MEDICARE or by reviewing the information that was included in the Medicare & You handbook that is mailed each Fall. The actual FY 2008 performance (reflecting CY 2007 enrollment) was approximately 90 percent. CMS has set the FY 2009 target at 91 percent and a long term target for FY 2012 set to increase to 93 percent, as developed in the HHS Strategic Plan.
The initial success in the enrollment of Medicare beneficiaries makes it difficult to substantially increase the targeted enrollment figure. Another challenge is receiving updated creditable coverage information from other organizations at the individual level to reflect current enrollment figures.

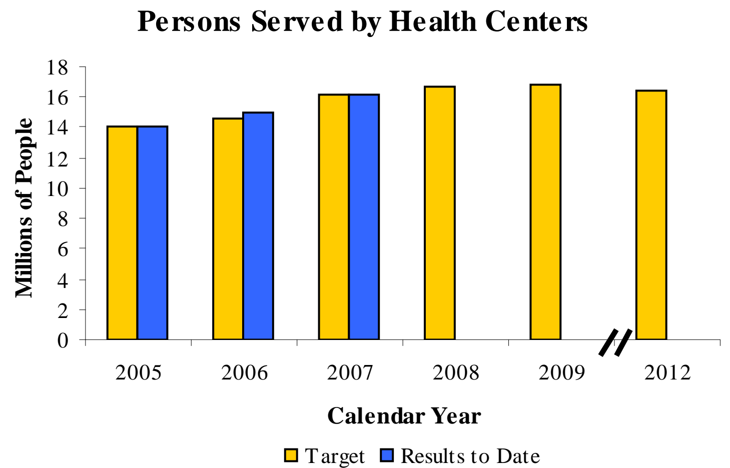
Data Source: The data for this measure is from CMS' Management Information Integrated Repository and updates from other external data sources.

Additional Measures Within Strategic Objective 1.1	Most Recent Performance	Additional Information Link
Reduce the percentage of improper payments made under the Medicare fee-for-service (FFS) program.	3.6 Percent in FY 2008 (Exceeded Target)	Measure Details

Strategic Objective 1.2: Increase health care services availability and accessibility.

Measure Spotlight: Increase the number of patients served by Health Centers.

The Health Centers Program provides grants to community-based organizations to deliver comprehensive, high quality, and cost-effective primary health care to populations in urban and rural areas that lack access to care. These populations include the poor, uninsured, and homeless; minorities; migrant and seasonal farm workers; public housing residents; and people with limited English proficiency.



Performance: Since 2002, the number of patients served by Health Centers has increased an average of 956,000 per year. This growth was fueled by the President's Health Centers Initiative, which was designed to significantly impact communities through the support of 1,200 new or expanded sites across the Nation.

In 2007, Health Centers served 16.1 million patients, meeting the target. The President's Health Centers Initiative funded 337 new and expanded sites, including 80 sites in high-poverty areas in 2007, bringing the total to 1,236 new and expanded sites since the beginning of the Initiative in 2002. The Program estimates that the Nation's health centers will serve 16.75 million patients in 2008 and 16.85 million in 2009.

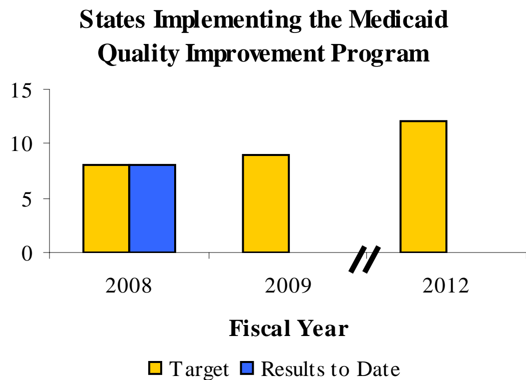
This continued growth in the number of patients served by Health Centers is dependent upon the rate of maturation of newly established sites, the efficiency of operations of all centers, policies of the Medicaid program and other State programs that support care to the uninsured, and public awareness of the availability of Health Center services. By providing technical assistance to health center sites on building their organizations, achieving efficiency of operations, improving quality of care, and conducting outreach to the public, the Health Centers Program is able to address some of these challenges and contribute to the growth in the number of communities and individuals with access to primary and preventive health care.

Data Source: The data for this measure is from the Health Resources and Services Administration (HRSA) Bureau of Primary Health Care Uniform Data System.

Additional Measures Within Strategic Objective 1.2	Most Recent Performance	Additional Information Link
Increase the number of person (all ages) with access to a source of ongoing care.	86.5 Percent of US population with access to ongoing care in FY 2007	Measure Details
Increase the proportion of 1) American Indian and Alaska Native (AI/AN) patients with diagnosed diabetes who receive an annual retinal examination; and 2) Increase the proportion of eligible American Indian and Alaska Native (AI/AN) patients who have had appropriate colorectal cancer screening.	49 Percent of Diabetic AI/AN Receive Annual Retinal Screening; 29 Percent Receive Appropriate Colorectal Cancer Screenings (Exceeded Targets)	Measure Details
Serve the proportion of racial/ethnic minorities in programs funded through the Ryan White HIV/AIDS Program at a rate that exceeds their representation in national AIDS prevalence data.	Eight Percentage Points Difference in FY 2006 (Exceeded Target)	Measure Details
Increase the number of client admissions to substance abuse treatment programs receiving public funding.	2.3 Million Client Admission in FY 2007 (Exceeded Target)	Measure Details

Strategic Objective 1.3: Improve health care quality, safety, cost, and value.

Measure Spotlight: Increase the number of States that have the ability to assess improvements in access and quality of health care through implementation of the Medicaid Quality Improvement Program.



Medicaid is a means-tested health care entitlement program jointly 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: The Medicaid Quality Improvement Program supports States in achieving safe, effective, efficient, timely, equitable, and patient-centered care. This long-term measure tracks the number of States participating in the program with the aim of establishing a national quality framework. In FY 2007, the Centers for Medicare & Medicaid Services (CMS) began a thorough review of data sources and data collection tools to document State quality activity. Comprehensive, individualized Quality Assessment Reports (QARs), the primary vehicle for improving States' ability to assess quality and access to care, were developed for both informational purposes and validation of State quality activities. CMS completed eight QARs, meeting its FY 2008 target to have 15 percent (eight States) participating. The FY 2009 target is to have nine States participating. The primary challenge in meeting these targets is that State participation is voluntary. Nonetheless, States recognize that participation in the development of a National Quality Framework for Medicaid presents important opportunities for improvement. States are looking to CMS for guidance in achieving improved outcomes for their Medicaid beneficiaries and programs. Engaging with representative groups, CMS is able to garner support from stakeholders and champions for State participation.

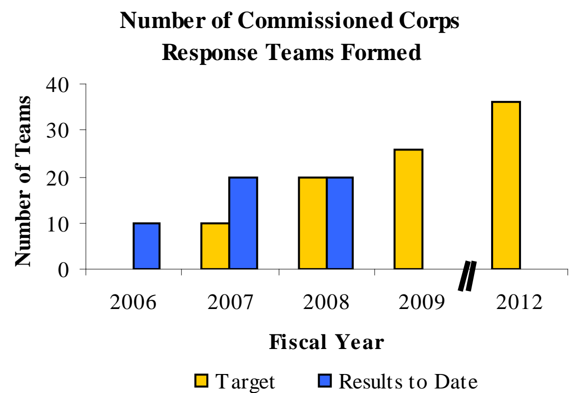
Data Source: The data is from State reports, including but not limited to State Quality Improvement Strategies, and External Quality Review Organization Reports.

Additional Measures in Strategic Objective 1.3	Most Recent Performance	Additional Information Link
Increase physician adoption of Electronic Health Records (EHRs).	14 Percent Use of EHR in FY 2007	Measure Details
Decrease the prevalence of restraints in nursing homes.	Five Percent in FY 2007 (Exceeded Target)	Measure Details

Strategic Objective 1.4: Recruit, develop, and retain a competent health care workforce.

Measure Spotlight: Increase the number of Commissioned Corps response teams formed.

The United States Public Health Service Commissioned Corps (one of the seven Uniformed Services of the United States) protects, promotes, and advances the health and safety of the Nation and is a key asset for HHS to effectively respond to bioterrorism and other public health challenges.



Performance: In FY 2007, as part of the ongoing transformation of the Commissioned Corps, HHS established a model for operational preparedness of the Corps. The new response structure consists of an increased number of organized and fully functional teams, which vary in size based on function and response needs. In FY 2007, twenty-six teams had been formed with twenty of those teams being fully trained and deployable, exceeding the target of 10 teams. The Corps was able to exceed this goal as a result of a one time allocation of funds for rapid deployment force training. In light of the FY 2008 funding level, the 20 fully trained teams were maintained and no new teams were formed nor trained. Nevertheless, the FY 2008 target of 26 teams formed and 20 fully trained and equipped was met. The FY 2009 target of 26 fully trained teams includes two Health and Medical Response teams.

Data Source: The data is from the Office of the Surgeon General, Office of Force Readiness and Deployment.

Additional Measures in Strategic Objective 1.4	Most Recent Performance	Additional Information Link
Increase the number of Commissioned Corps Officers.	6,215 Officers (Exceeded Target)	Measure Details

Strategic Goal Two: Public Health Promotion and Protection, Disease Prevention, and Emergency Preparedness

Prevent and control disease, injury, illness, and disability across the lifespan, and protect the public from infectious, occupational, environmental, and terrorist threats.

The four broad objectives under Public Health Promotion and Protection, Disease Prevention, and Emergency Preparedness are:

- Objective 2.1: Prevent the spread of infectious diseases;
- Objective 2.2: Protect the public against injuries and environmental threats;
- Objective 2.3: Promote and encourage preventive health care, including mental health, lifelong health behaviors, and recovery; and
- Objective 2.4: Prepare for and respond to natural and man-made disasters.

Throughout the 20th century, advances in public health and medicine resulted in reduced mortality and morbidity from infectious diseases. Chronic diseases, such as heart disease, stroke, cancer, and diabetes replaced infectious diseases as the major cause of illness and death in the United States in the latter part of the 20th century. Infectious diseases have reemerged as a priority for public health in the United States. For example, risky behaviors such as unprotected sex and injection drug use continue to result in new HIV/AIDS infections. The proportion of persons with HIV infections diagnosed before progression to AIDS increased from 78.1 percent in 2002 to 79.7 percent in 2006. The percentage of individuals who report having used an illicit drug within the previous 30 days improved slightly from 8.3 percent 2002 to 8 percent in 2007.

Strategic Goal Two Success Story: HIV/AIDS Information Gateway

A gateway to all Federal domestic HIV /AIDS information and resources, found at www.AIDS.gov, now has an innovative look and feel that incorporates a blog, podcasts, and other new media tools. The website focuses on using interactive forms of communication in the fight against HIV/AIDS. Website visitors can listen to and view a monthly podcast series, which feature a government official talking about topics affecting the lives of people living with, or at risk for, HIV/AIDS. Many HHS agencies collaborate to make AIDS.gov a user-friendly, accessible, and helpful source of information. Non-HHS partners include the Department of Housing and Urban Development, the Department of Veterans Affairs, the White House Office of National AIDS Policy, and the Department of State's Office of the U.S. Global AIDS Coordinator. The site includes the latest HIV/AIDS news, basic HIV/AIDS information, information on prevention, education, treatment, and care resources.

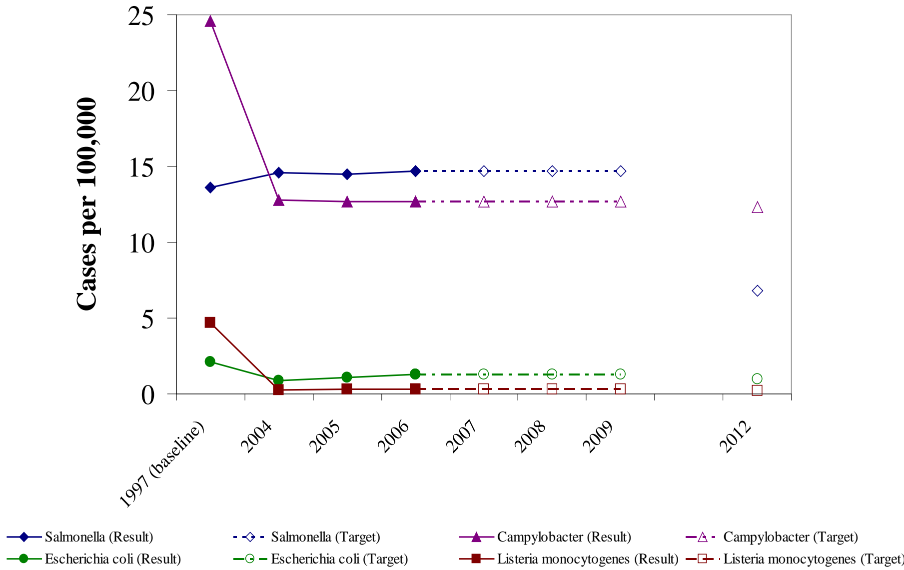
Foodborne diseases cause an estimated 76 million illnesses; 325,000 hospitalizations; and 5,000 deaths in the United States each year. On December 11, 2007, Secretary Leavitt signed two Memoranda of Agreement between HHS and two Chinese government agencies to improve the safety of food, feed, drugs, and medical devices. The Food and Drug Administration (FDA) has established offices in China and four other regions that export food and other FDA-regulated products to the United States. Vaccinations protect individuals, and through herd immunity, vaccinations also protect communities. Ninety percent coverage for early childhood immunizations was met in FY 2007 for most vaccines with the exception of pneumococcal conjugate vaccine and the fourth dose of Diphtheria-Tetanus-Pertussis. Public health emergencies have become a significant focus for public health at the Federal, State and local levels. The Strategic National Stockpile (SNS) permits HHS to respond to mass trauma events by delivering medical supplies to any point in the United States within 12 hours. At the end of FY 2008, 80 percent (43/54) of the States and directly-funded cities demonstrated preparedness to use SNS assets, not reaching the 90 percent target. The primary challenge for this program continues to be recruitment, and training of staff and volunteers to execute a mass prevention plan due to the number of competing priorities and initiatives at the State and local level.

The table below shows HHS' progress in meeting targets for Strategic Plan measures for Strategic Goal 2 in this document.

Fiscal Year	Total Targets	Targets with Results Reported	Percent of Targets with Results Reported	Total Targets Met	Percent of Targets Met
2005	13	13	100%	8	62%
2006	19	14	74%	8	57%
2007	21	11	52%	3	27%
2008	18	5	28%	4	80%

Strategic Objective 2.1: Prevent the spread of infectious disease.

Measure Spotlight: Reduce the incidence of infection with key foodborne pathogens.



HHS supports activities to reduce or prevent the incidence of foodborne illness associated with key pathogens.

Performance: Federal, Tribal, and State partners have used research, inspections, surveillance, standardization and education as strategies to improve food safety. Foodborne illness surveillance information is used to determine what additional food safety strategies are needed and to measure the effectiveness of interventions over time. The foodborne illness incidence data did not change significantly between 2004 and 2006, the most recent year for which data is available. Incidence of illnesses caused by *Campylobacte*r species, *E. coli* O157:H7, and *Listeria monocytogenes* decreased significantly between 1997 and 2004, approaching the 50% reduction goal. Attribution information for pathogens and foods is useful to focus future prevention and intervention efforts. Further investigation is needed to identify sources for emerging *Salmonella* serotypes, since the rate of infection has increased in the past decade.

The Nation's challenges to food protection are increasing as consumers buy food from around the globe. FDA's *Food Protection Plan* features science and risk-based approach of prevention, intervention, and response to ensure the safety of domestic as well as imported foods.

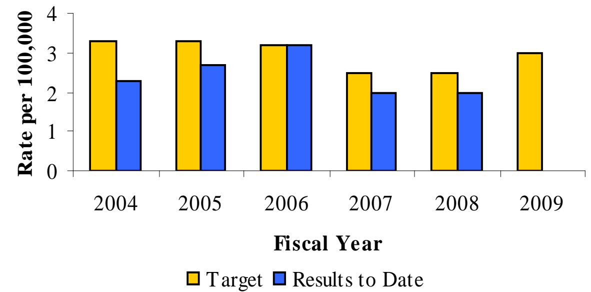
Data Source: The data for this measure is FoodNet (the Foodborne Diseases Active Surveillance Network) and the Healthy People 2010 Food Safety Progress Review.

Additional Measures Within Strategic Objective 2.1	Most Recent Performance	Additional Information Link
Achieve or sustain immunization coverage of at least 90% in children 19 to 35 months of age for: a) 4 doses of Diphtheria-Tetanus-Pertussis (DtaP) vaccine; b) 3 doses of polio vaccine; c) 1 dose of Measles-Mumps-Rubella (MMR) vaccine; d) 3 doses of hepatitis B vaccine; e) 3 doses of Haemophilus influenzae type b (Hib) vaccine; f) 1 dose of varicella vaccine; and g) 4 doses of pneumococcal conjugate vaccine (PCV7).	DTaP at 85 Percent; Polio at 93 Percent; MMR at 92 Percent; Hepatitis B at 93 Percent; HIB at 93 Percent; Varicella at 90 Percent; PCV7 at 75 Percent Immunization Coverage in FY 2007.	Measure Details
Increase the proportion of people with HIV diagnosed before progression to AIDS.	79.7 Percent Diagnosed before Progression to AIDS in FY 2006 (Exceeded Target)	Measure Details
Increase the rate of influenza vaccination: a) In persons 65 years of age and older; and b) Among noninstitutionalized adults at high risk, aged 18 to 64.	69 Percent for 65 Years of Age and Older in FY 2006 (Target Not Met); 34 Percent for High Risk Adults (Exceeded Target)	Measure Details

Strategic Objective 2.2: Protect the public against injuries and environmental threats.

Measure Spotlight: Reduce nonfatal work-related injuries among youth ages 15 to 17; and reduce fatal work-related injuries among youth ages 15 to 17.

The Centers for Disease Control and Prevention's (CDC) Occupational Safety and Health program seeks to reduce young worker injuries.



Performance: Rates of fatal and nonfatal injuries among young workers have steadily declined from 5.2 fatal injuries per 100,000 full-time equivalent employees (FTE) and 3.5 non-fatal injuries per 100 FTE in FY 2003. Consistent with prior performance, CDC exceeded its FY 2008 target to reduce non-fatal injuries to 4.4 non-fatal injuries per 100 FTE with an actual result of 4.2 per 100 FTE. Its target of reducing fatal injuries to 2.5 fatal injuries per 100,000 FTE was also exceeded with an actual reduction to 2.0 fatal injuries per 100,000 FTE. These reductions in young worker injuries have been achieved through an increased awareness of the issue, recent changes in child labor laws, and recently finalized curricula that increase young workers' basic knowledge of workplace safety and health. Despite the program's success, obstacles still remain to maintain a low rate of young worker injuries. Barriers to reducing young worker injuries include the minimal application of child labor laws in the high-risk agricultural injury sector and limited opportunities to introduce new work safety curricula into schools. CDC seeks to improve information translation to partners and other public health consumers. In FY 2009, CDC will work toward achieving a case rate of 4.4 non-fatal injuries per 100 FTE and 3 fatalities per 100,000 FTE.

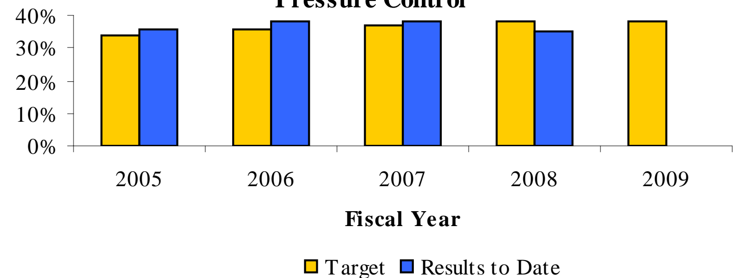
Data Source: The data for non-fatal injuries is from the National Electronic Injury Surveillance System and for fatal injuries from the Census of Fatal Occupational Injuries (a special research file provided by Bureau of Labor Statistics).

Strategic Objective 2.3: Promote and encourage preventive health care, including mental health, lifelong health behaviors, and recovery.

Measure Spotlight: Reduce complications of diabetes by increasing the proportion of American Indian/Alaska Native patients with diagnosed diabetes that have achieved blood pressure (BP) control(<130/80).

The mission of the Indian Health Service (IHS) Division of Diabetes Treatment and Prevention Program is to develop, document, and sustain a public health effort to prevent and control diabetes in American Indians and Alaska Natives.

Performance: The program met its annual targets for this measure from FY 2005 to 2007. This high priority treatment measure requires monitoring, frequent visits, and patient compliance in order to achieve an appropriate level of BP control. Patient education and coordination of care continue to be critical strategies to meet targets. The program did not meet its FY 2008 target of 38 percent of patients with diabetes demonstrating blood pressure control for the Diabetes Audit. The program faces many challenges in ensuring that patients have achieved blood pressure control, which generally results from blood pressure lowering medications, increased medical visits, and healthy lifestyle practices.

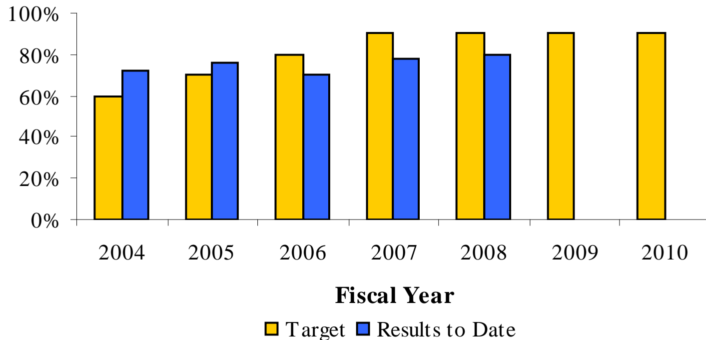


Data Source: Measure data is from IHS's Annual Diabetes Care and Outcomes Audit.

Additional Measures Within Strategic Objective 2.3	Most Recent Performance	Additional Information Link
Increase the proportion of women aged 40 and older who have received a mammogram within the preceding 2 years.	76.6 Percent in FY 2006	Measure Details
Reduce 30-day use of illicit substances (age 12 and older).	8 Percent in FY 2007 (Target Not Met)	Measure Details
Reduce the number of suicide deaths.	32,637 in Calendar Year 2006	Measure Details

Strategic Objective 2.4: Prepare for and respond to natural and man-made disasters.

Measure Spotlight: Increase the percentage of State public health agencies prepared to use materiel contained in the Strategic National Stockpile (SNS).



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

Performance: At the end of FY 2008, 80 percent (43 out of 54) of the States and directly-funded cities demonstrated preparedness to use SNS assets, not reaching the 90 percent target. Through FY 2005, the results of the Centers for Disease Control and Prevention's (CDC) assessment of SNS preparedness exceeded performance targets. During FY 2006, the SNS program revised the standards used to assess SNS preparedness. In FY 2007 the program began conducting more rigorous assessments by requesting and analyzing additional data for each plan element that demonstrates preparedness. These efforts are intended to increase grantee preparedness to effectively manage and use deployed SNS materiel. Enhanced assessments, planning efforts, technical assistance, training, and exercises will contribute to improved performance during a public health emergency.

The primary challenge for this program continues to be recruitment, and training of staff and volunteers to execute a mass prophylaxis plan due to the number of competing priorities and initiatives at the State and local level. Some jurisdictions lack proper facilities to receive SNS materiel. Improved coordination between State and local agencies that are responsible for disaster preparedness is also a continuing challenge. Although more stringent standards and additional challenges may cause grantee status to fluctuate, the SNS program remains committed to the long term target of 100 percent of States and directly-funded cities that are prepared to use SNS materiel and the incremental targets to improve preparedness. Appropriated funds allow the SNS program to finance the procurement of critical pharmaceuticals and vaccines needed to protect Americans from threat agents and support the capacity to deliver drugs, vaccines, and supplies anywhere in the Nation within 12 hours. CDC will continue to evaluate the preparedness planning efforts of State and local public health agencies through exercises and reviews of SNS distribution plans.

CDC, in collaboration with the National Association of County and City Health Officials and the Association of State and Territorial Health Officials is acting on findings of a recent survey by conducting regional meetings to collect, review, and share State and locally developed tools, templates, processes, plans, and other resources deemed by State and local public health, medical and emergency management experts as worthy of promoting as a national best practice. To assist with testing and validating State and local SNS plans, two modeling and simulation projects are also underway. Technical assistance and other resources for SNS preparedness information include listservs, satellite web casts, extranet sites, and SNS sponsored training courses.

Data Source: The data for this measure is from the fourth quarter report on CDC evaluation of standard functions using SNS Assessment Tools, based on criteria outlined in A Guide for Preparedness, V.10.00.

Additional Measures Within Strategic Objective 2.4	Most Recent Performance	Additional Information Link
Increase the number of States and territories that include persons with disabilities in emergency management plans and responses.	30 States in FY 2008 (Met Target)	Measure Details

Strategic Goal Three: Human Services

Promote the economic and social well-being of individuals, families, and communities.

The four broad objectives under Human Services are:

- Objective 3.1: Promote the economic independence and social well-being of individuals and families across the lifespan;
- Objective 3.2: Protect the safety and foster the well-being of children and youth;
- Objective 3.3: Encourage the development of strong, healthy, and supportive communities; and
- Objective 3.4: Address the needs, strengths, and abilities of vulnerable populations.

Since welfare reforms were passed over a decade ago, the employment rates of current and former welfare recipients have risen, and caseloads have diminished dramatically. Earnings for welfare recipients have increased, as have earnings for female-headed households. Additionally, child poverty rates have declined substantially since the start of the Temporary Assistance for Needy Families (TANF) program in 1997. Despite these successes in prior years, HHS still had much work to do in FY 2008 to promote the economic and social well-being of individuals, families and communities. Self-sufficiency continues to be elusive for many individuals remaining on welfare. However, the job entry rate among TANF recipients for FY 2007 was nearly 36 percent, almost meeting the goal of 37 percent. Although the program narrowly missed this target, the measure improved slightly from the prior year. Success on this indicator means that more families are financially independent and not dependent on Federal and State assistance.

The needs of vulnerable children continue to be a priority for HHS. In 2007, there were approximately 51,000 children adopted into safe and permanent homes. At its current FY 2007 rate of adoptions 10 percent, the adoption rate measure has already surpassed its FY 2006 target rate of 9.90 percent. The FY 2009 target for the adoption rate is 10.10 percent.

Strategic Goal Three Success Story: "Own Your Future" Initiative

HHS continues to increase the public's awareness about the importance of long-term care planning through the "Own Your Future" initiative. This initiative, administered by our Centers for Medicare & Medicaid Services (CMS), Administration on Aging (AoA), and Office of the Assistant Secretary for Planning and Evaluation, will help Americans take an active role in planning for their future long-term care needs. Approximately 13 million Americans needed long-term care in 2000. This number is expected to grow substantially in the next 30 years as the population ages. The Bureau of the Census estimates that the percentage of the population 65 and older will rise from 12.6 percent in 2000 to 20.5 percent in 2040, and the percentage of the population aged 85 and older will rise from 1.6 percent in 2000 to 3.8 percent in 2040. These demographic changes point to a predictable increase in demand for long-term care services.

As the American population ages, enhanced efforts are needed to help the growing number of older persons remain active and healthy. The need for long-term care services will also increase, and availability of home and community based services will be increasingly important to help people maintain their independence and quality of life. People with disabilities, refugees and other migrants, and other vulnerable populations also need assistance and protection to achieve and sustain economic independence and self-sufficiency, as well as social well-being.

The table below shows HHS' progress in meeting targets for Strategic Plan measures for Strategic Goal 3 in this document.

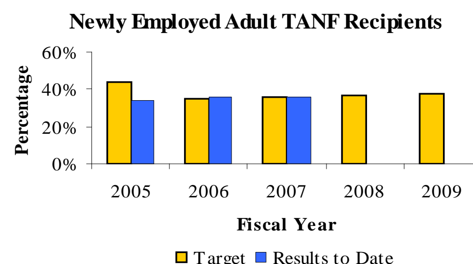
Fiscal Year	Total Targets	Targets with Results Reported	Percent of Targets with Results Reported	Total Targets Met	Percent of Targets Met
2005	13	13	100%	7	54%
2006	16	15	94%	8	53%
2007	17	13	76%	7	54%
2008	18	5	28%	4	80%

Strategic Objective 3.1: Promote the economic independence and social well-being of individuals and families across the lifespan.

Measure Spotlight: Increase the percentage of adult TANF recipients who become newly employed.

The Temporary Assistance for Needy Families (TANF) program grants States Federal funds and wide flexibility to operate programs designed to: provide assistance to needy families so that children may be cared for in their own homes; end dependence of needy parents by promoting job preparation, work, and marriage; prevent and reduce the incidence of out-of-wedlock pregnancies; and encourage two-parent families.

Performance: States have had success in moving TANF recipients to work, as evidenced by an increase in the job entry rate from 34 percent in FY 2003 to 36 percent in FY 2007, although the target of 37 percent was narrowly missed. Several factors have contributed to this recent accomplishment, including the Administration for Children and Families' (ACF) commitment to research, the identification and dissemination of information on the effects of alternative employment strategies, and targeted technical assistance efforts. In addition to the significant economic downturn, ACF faces several challenges in meeting its targets. The program is a block grant that gives States flexibility in serving clients, making it difficult to directly influence the results. The measure is influenced by outside factors, such as client skills, education, and State labor markets. The Deficit Reduction Act of 2005 (DRA) and the final DRA regulations signaled that States needed to renew efforts to move recipients into work or face significant fiscal penalties.



Data Source: Data is obtained through the National Directory of New Hires.

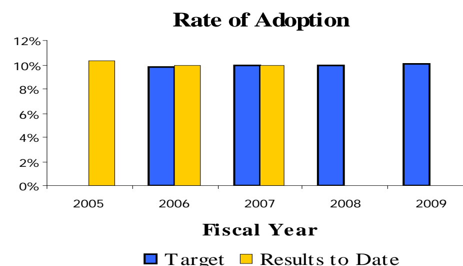
Additional Measures Within Strategic Objective 3.1	Most Recent Performance	Additional Information Link
Increase the percentage of individuals with developmental disabilities reached by State Councils on Developmental Disabilities who are independent, self-sufficient, and integrated into the community.	12.46 Percent in FY 2007 (Did Not Meet Target)	Measure Details
Increase the child support collection rate for current support orders.	61 Percent in FY 2007 (Met Target)	Measure Details

Strategic Objective 3.2: Protect the safety and foster the well-being of children and youth.

Measure Spotlight: Increase the adoption rate for children involved in the Child Welfare System.

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.

Performance: The adoption rate measures the effectiveness of Federal child welfare and adoption programs. Data indicates that the adoption rate increased between FY 1996 and FY 2002. Preliminary data indicate that there were over 51,000 adoptions in FY 2007 and that the adoption rate was 10 percent, surpassing the target rate of 9.9 percent. The FY 2009 target for the adoption rate is 10.1 percent. One challenge ACF faces as it works with states to meet this target is finding homes for older children in foster care. About 43 percent of foster care children awaiting adoptive families are over the age of nine. The program is using a number of strategies to meet the challenge of finding adoptive families for children in foster care. For instance, nearly 10,000 children featured on the AdoptUsKids photo listing website have been placed for adoption since its inception. The program continues to use public service announcements (PSAs) to promote adoption.



Data Source: Data is from ACF's Adoption and Foster Care Analysis and Reporting System (AFCARS).

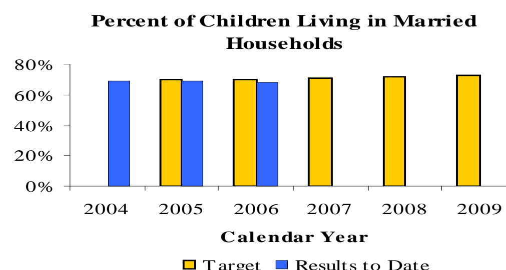
Additional Measures Within Strategic Objective 3.2	Most Recent Performance	Additional Information Link
Increase the percentage of Head Start programs that achieve average fall to spring gains of: a) At least 12 months in word knowledge; and b) At least four counting items.	N/A	Measure Details
Increase the percentage of children receiving Children's Mental Health Services who have no interaction with law enforcement in the 6 months after they begin receiving services.	71.1 Percent in FY 2007 (Exceeded Target)	Measure Details

Strategic Objective 3.3: Encourage the development of strong, healthy, and supportive communities.

Measure Spotlight: Increase the number of children living in married couple households as a percentage of all children living in households.

The Temporary Assistance for Needy Families (TANF) program grants States Federal funds and wide flexibility to operate programs designed to: provide assistance to needy families so that children may be cared for in their own homes; end dependence of needy parents by promoting job preparation, work, and marriage; prevent and reduce the incidence of out-of-wedlock pregnancies; and encourage the formation and maintenance of two-parent families.

Performance: This measure demonstrates the program's progress in promoting healthy marriage. Research indicates that children who grow up in two-parent, married households have a more solid foundation for success than children who grow up in non-married households or without their father present. Progress in increasing the rate has been small since the measure was first established in FY 2004 with a baseline of 69 percent. In 2006, 68 percent of children resided in married-couple families, missing the target of 70 percent. We anticipate that 2007 data will be completed by the Census Bureau in early 2009. ACF will continue to use a number of strategies to meet the challenges of affecting this rate. ACF may be able to influence this measure through the new Healthy Marriage and Responsible Fatherhood Initiatives, funded by the Deficit Reduction Act of 2005 (DRA) as a companion to TANF. ACF anticipates that these efforts may eventually help achieve the FY 2009 target. Nevertheless, the efforts may not reach enough households to make a notable impact on the national rate. Considering all of these factors, the FY 2009 target of 73 percent is ambitious and would signal significant progress.



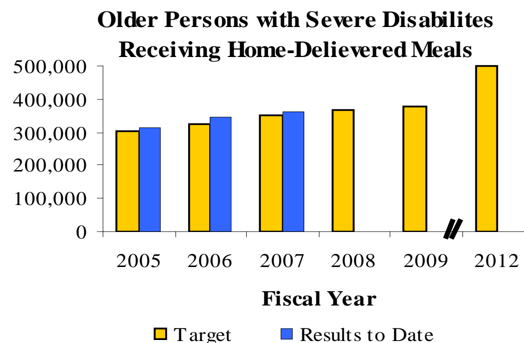
Data Source: The data is obtained from Census Bureau surveys.

Strategic Objective 3.4: Address the needs, strengths, and abilities of vulnerable populations.

Measure Spotlight: Increase the number of older persons with severe disabilities who receive home-delivered meals.

The Administration on Aging's (AoA) State and Community-Based Services program provides home and community-based support to the elderly so that they may lead healthier and more independent lives.

Performance: An individual is considered severely disabled if they have three or more activities-of-daily-living (ADL) limitations, which is a level consistent with nursing home eligibility in most States. These limitations include activities related to personal care, such as bathing or eating. In FY 2007, the Aging Services Network provided home-delivered meals to 359,143 seniors with severe disabilities. AoA exceeded its projected target of 350,568 by 2.5 percent, serving 8,575 more people with severe disabilities than projected for FY 2007. This better-than-expected performance can be attributed to the Aging Services Network's efforts which target severely-disabled seniors. These included more States integrating Medicaid Waiver services with Aging Services Programs and demonstration projects. The FY 2010 target is 387,026. The program faces several challenges in meeting its goal to annually increase the number of severely-disabled clients who receive home-delivered meals, including the accelerating pace of food cost inflation and significant fuel cost increases which impact the cost of delivering meals. AoA is striving to address these challenges by working closely with States and the Aging Services Network to develop management efficiencies and local community support that will enhance service provision and continue targeting those most in need.



Data Source: The data is from AoA's National Aging Program Information System, available on the AGID database http://www.data.aoa.gov/

Additional Measures Within Strategic Objective 3.4	Most Recent Performance	Additional Information Link
Increase the percentage of refugees entering employment through refugee employment services funded by ACF.	53 percent in FY 2007 (Did Not Meet Target)	Measure Details

Strategic Goal Four: Scientific Research and Development

Advance scientific and biomedical research and development related to health and human services.

The four broad objectives under Scientific Research and Development are:

- Objective 4.1: Strengthen the pool of qualified health and behavioral science researchers;
- Objective 4.2: Increase basic scientific knowledge to improve human health and human development;
- Objective 4.3: Conduct and oversee applied research to improve health and well-being; and
- Objective 4.4: Communicate and transfer research results into clinical, public health, and human service practice.

People are living longer as a result of successes in preventing and treating acute and short-term conditions such as heart attacks, stroke, cancer, and many infectious diseases. An increasingly older population faces the new challenges of multiple chronic conditions that now consume 75 percent of health care expenditures. The Nation is in a continuous race against the health and economic consequences of disease and human suffering. Therefore, we must utilize research and development to its maximum capacity to transform health care, public health, and human service prevention efforts.

Strategic Goal Four Success Story: Education on Upper GI Bleeding

AHRQ is pleased to provide a new patient education tool to consumers and healthcare providers that can help prevent upper GI bleeding and other complications which can occur as a side effect of medication use. The Agency supported development of "Your Guide to Coumadin® /Warfarin Therapy," an easy-to-read brochure that explains warfarin treatment and medication safety for patients who experience blood clots, heart attack, stroke, and other conditions. This drug is used to help the blood flow more easily and not clot. It requires close monitoring and can lead to uncontrolled bleeding, including upper gastrointestinal (GI) complications. The Coumadin® guide is available at http://www.ahrq.gov/consumer/coumadin.htm

Basic science is the foundation for improved health and human services. Once a basic discovery is made, the findings must be applied and translated into practice for health and human service improvement to result. This continuum from basic to applied research to practice is a significant emphasis of HHS' scientific research and development enterprise. Advances cannot be accomplished without qualified researchers working with, or for, HHS. The scientific labor market is highly competitive. HHS' National Institutes of Health (NIH) seeks to build and maintain a population of scientists that is well educated, highly trained, and dedicated to meeting the Nation's future health-related research needs primarily through its Extramural Research Training Program, and also through its Intramural Research efforts. NIH exceeded the training program's annual goals by initiating new research training and fellowship initiatives. In FY 2007, NIH post-doctoral scientists who had participated in the National Research Service Award Program had a 13 percent higher success rate for continuing participation in NIH-funded research within the following ten years as compared to their peers who did not participate in the program. This result exceeds the program goal of 12 percent. The Department will continue creating effective strategies to recruit and retain scientific experts to conduct and oversee research activities, and review applications for medical products.

The following pages discuss the performance indicators that support strategic goal 4 and highlight HHS' recent accomplishments and future targets.

The table below shows HHS' progress in meeting targets for Strategic Plan measures for Strategic Goal 4 in this document.

Fiscal Year	Total Targets	Targets with Results Reported	Percent of Targets with Results Reported	Total Targets Met	Percent of Targets Met
2005	7	7	100%	7	100%
2006	7	7	100%	7	100%
2007	10	10	100%	9	90%
2008	9	4	40%	4	100%

Strategic Objective 4.1: Strengthen the pool of qualified health and behavioral science researchers.

Measure Spotlight: Through the National Research Service Award Program, increase the probability that scientists continue participation in NIH-funded research within the following 10 years: a) Postdoctoral fellows; and b) Predoctoral trainees and fellows.

The overall goal of the National Institute of Health (NIH) Extramural Research Training Program is to build and maintain a population of scientists that is well educated, highly trained, and dedicated to meeting the Nation's future health-related research needs. The extramural grant programs of NIH support a broad range of research education, training, and career development activities that utilize a variety of support mechanisms to meet NIH research training and career development goals.

Performance: Since 2005, NIH has routinely met or exceeded this training program measure by adapting to the evolving needs of science, for example, by implementing new programs and policies for early-stage investigators and developing new research training and fellowship initiatives. Through these and other efforts to manage the program, NIH ensures that its trainees and fellows are better prepared to initiate and maintain careers in biomedical research. The results demonstrate that those funded by NIH are better able to compete for funding and to stay active as researchers in the years following their training. In 2008, NIH postdoctoral fellows were at least 13 percent more likely to remain active in biomedical research than non-NIH fellows, exceeding the target of 12 percent. NIH predoctoral trainees and fellows were 14 percent more likely to remain active than non-NIH trainees and fellows, meeting the annual target of 12 percent.

Data Source: The data for this measure are drawn from the NIH's IMPAC II database and the Doctorate Records File.

Strategic Objective 4.2: Increase basic scientific knowledge to improve human health and human development.

Measure Spotlight: Develop a novel advanced pattern recognition algorithm to analyze data obtained from imaging technologies to aid clinicians in diagnosing the earliest stage of disease, e.g., brain cancer.

The National Center for Toxicological Research (NCTR) supports efforts to enhance product safety by creating new and sophisticated analytical models that will assist the Food and Drug Administration (FDA) in assessing regulated products. Performance: NCTR scientists in the Division of Systems Toxicology designed and trained a prototype pattern recognition algorithm to detect normal and anomalous tissue using non-invasive magnetic resonance spectroscopy (MRS) brain scans. The advanced pattern recognition algorithm was developed to increase the ease and accuracy of interpreting complex MRS scans that are expected to detect early-stage cancers. In FY 2008, the experiment was expanded to include more than 130 brain scans which provided confirmation that the approach can provide enough information to classify and grade tumors at least an 85% accuracy rate.

The goal of this project is to work with private sector partners to develop and apply pattern recognition algorithms to identify early biomarkers of brain disease or cancer. This project may lead to improved tumor diagnostic techniques and provide more affordable noninvasive tissue screening for disease. FDA is evaluating whether pattern recognition technology can be successfully applied as an interpretation aid for MRS scans. NCTR's ability to meet its 2009 goal to develop a Cooperative Research and Development Agreement (CRADA) partnership is contingent on NCTR improving the algorithm's classification accuracy rate to 90 percent or better. This is a requirement of the potential CRADA partner before entering into a formal agreement. To improve the accuracy rate, NCTR has developed a software program that can recalibrate the brain scans and possibly lead to an improvement in the algorithm's accuracy rate. If the formal CRADA is established, acquiring more MRS scans for expansion to other tissues and diseases in 2009 is possible.

Data Source: The data for this measure is from NIH study data.

Additional Measures Within Strategic Objective 4.2	Most Recent Performance	Additional Information Link
Develop and apply clinically one new imaging technique to enable tracking the mobility of stem cells within cardiovascular tissues.	Undertaken studies of nature of stem cell migration in FY 2007 (Met Target)	Measure Details
Identify at least one clinical intervention that will delay the progression or the onset of Alzheimer's disease (AD) or prevent it.	Identified/characterized two particularly promising target molecules in FY 2007 (Met Target)	Measure Details

Strategic Objective 4.3: Conduct and oversee applied research to improve health and well-being.

Measure Spotlight: Conduct clinical trials to assess the efficacy of at least three new treatment strategies to reduce cardiovascular morbidity/mortality in patients with type 2 diabetes and/or chronic kidney disease.

The National Institutes for Health (NIH) is addressing a significant public health problem by seeking to evaluate approaches for reducing cardiovascular disease (CVD) outcomes, such as heart attacks and strokes, in patients with type 2 diabetes and/or chronic kidney disease for whom premature CVD is the major cause of death. Application of the results of the trials, if favorable, would extend the lifespan and improve the quality of life for persons with type 2 diabetes or chronic kidney disease.

Performance: NIH has been successful in achieving the annual targets, which are derived from a set of major, multicenter, randomized clinical trials. The set of trials is unparalleled in scope and research intensity and, collectively, could not be replicated by other organizations. The Look AHEAD clinical trial one-year outcome data paper on the success of the one-year intensive weight loss intervention and its impact on CVD risk factors was published in Diabetes Care in 2007. In 2008, the Look AHEAD Data Safety and Monitoring Board reviewed and evaluated the raw data from the study's indicators to date, including safety-monitoring analyses, data quality, participant retention, and emerging positive or negative outcome trends, and has made a determination that the science is progressing appropriately and the trial should continue. Research outcomes are challenging to predict with a high degree of accuracy, but can be captured in many cases with milestones of progress toward the goal. Although outcomes may encompass the proposed hypothesis, unplanned results such as serendipitous discoveries and findings that narrow the research focus can be just as significant.

Data Source: The data for this measure is from NIH study data.

Strategic Objective 4.4: Communicate and transfer research results into clinical, public health, and human service practice.

Measure Spotlight: Reduce the financial cost (or burden) of upper gastrointestinal (GI) hospital admissions by implementing known research findings.

The Agency for Healthcare Research and Quality (AHRQ) manages the Effective Health Care Program, which supports the development of new comparative effectiveness research through research on the outcomes of health care services and therapies by comparing different therapies for the same condition.

Performance: Results show that from FY 2005 through FY 2007, the number of admissions for GI bleeding have generated a drop in per capita charges for GI bleeding. AHRQ's targets have consistently been met. In FY 2004, baseline rates were established ($96.54 per capita). In FY 2006, the target was a 3 percent drop and the actual result was a 3.2 percent drop ($93.36 per capita). In FY 2007, the target was a 4 percent drop and the actual result was a 4.9 percent drop ($91.81 per capita). The most recent results from FY 2008 slightly exceeded the target; the FY 2008 target was a 5 percent drop and the actual result was a 5.1 percent drop ($87.10 per capita). Given the past trend, it is reasonable to expect that hospitalization for upper GI bleeding due to adverse events of medication or inappropriate treatment of peptic ulcer disease in those between 65 and 85 years of age will decrease and the decreased number of admissions will continue to generate a per year drop in per capita charges. The targets selected for FY 2009 and 2010 are a 6 percent and 7 percent drop compared to the baseline respectively. AHRQ faces many challenges in meeting its performance for this measure because external factors may prevent health care professionals from implementing findings from AHRQ funded-research. For instance, physicians may not have the knowledge or tools to educate their patients on the appropriate use of anti-clotting drugs which may increase the risk of GI bleeding and hospitalizations. To help this, AHRQ recently developed an easy-to-read brochure that explains warfarin treatment called "Your Guide to Coumadin/Warfarin Therapy". Each year thousands of consumers are prescribed the anti-clotting drug warfarin (Brand name: Coumadin ®), which is a dangerous medication that requires close monitoring and can lead to uncontrolled bleeding, including GI bleeding. Information on the Coumadin guide is available at http://www.ahrq.gov/consumer/coumadin.htm.

Data Source: The data for this measure is from AHRQ's Healthcare Cost and Utilization Project.

Additional Measures Within Strategic Objective 4.4	Most Recent Performance	Additional Information Link
Increase the number of AoA-supported community-based sites that use evidence-based disease and disability prevention programs.	24 Sites in FY 2007 (Met Target)	Measure Details
Reduce the disparity between African-American and White infants in back sleeping by 50% to reduce the risk of Sudden Infant Death Syndrome.	Distributed 47,000 campaign materials in FY 2008 (Met Target)	Measure Details

Analysis of Financial Statements and Stewardship Information Section

For the tenth consecutive year, HHS obtained an unqualified or "clean" audit opinion on its financial statements. The financial statements were prepared in accordance with Federal accounting standards and audited by the independent accounting firm of Ernst & Young LLP under the direction of the Department's Inspector General. The *Chief Financial Officers Act* requires preparation and audit of these statements, which are part of the Department's efforts for continuous improvement of financial management. The production of accurate and reliable financial information is necessary for sound decision-making, assessing performance, and allocating resources. The Department's audited financial statements and notes are presented in Section II of the HHS Annual Financial Report (AFR). Section II of the AFR is available online at: http://www.hhs.gov/afr/2008sectionii-fs.pdf

The following chart summarizes trend information concerning components of our financial condition – assets, liabilities, and net position. The Consolidated Balance Sheet presents a snapshot of our financial condition as of September 30, 2008, compared to FY 2007, and displays assets, liabilities and net position. More information on the Department's financial condition can be accessed at: http://www.hhs.gov/afr/2008sectioni.pdf.

Financial Condition *(Dollars in Billions)*	**FY 2004**	**FY 2005**	**FY 2006**	**FY 2007**	**FY 2008**	**Increases (Decrease)**	**Percent Change**
Total Assets	$403.8	$428.5	$513.9	$503.8	$529.3	$25.5	5.1%
Fund Balance with Treasury	$97.7	$99.6	$159.9	$114.8	$124.3	$9.5	8.3%
Investments, Net	$287.9	$300.7	$342.0	$365.9	$385.4	$19.5	5.3%
Other Assets	$18.2	$28.2	$12.0	$23.1	$19.6	($3.5)	(15.2%)
Total Liabilities	**$66.8**	**$71.0**	**$78.4**	**$81.9**	**$86.6**	**$4.7**	**5.7%**
Accounts Payable	$1.4	$1.1	$1.2	$1.0	$1.0	$0.0	0.0%
Entitlement Benefits Due and Payable	$49.2	$53.8	$61.2	$61.5	$65.9	$4.4	7.2%
Accrued Grant Liabilities	$3.8	$3.8	$3.8	$3.9	$3.9	$0.0	0.0%
Federal Employee & Veterans Benefits	$7.2	$7.2	$7.5	$8.4	$8.8	$0.4	4.8%
Other Liabilities	$5.2	$5.1	$4.7	$7.1	$7.0	($0.1)	(1.4%)
Net Position	**$337.0**	**$357.5**	**$435.5**	**$421.9**	**$442.7**	**$20.8**	**4.9%**
Total Liabilities and Net Position	**$403.8**	**$428.5**	**$513.9**	**$503.8**	**$529.3**	**$25.5**	**5.1%**

Another component of our financial picture is our Consolidated Statement of Net Cost. Our net cost of operations represents the difference between the costs incurred by our program less revenues. We receive the majority of funding through Congressional appropriations and reimbursement for the provision of goods or services to other Federal agencies. HHS' net cost of operations for the year ended September 30, 2008 totaled $709.1 billion. The majority of our FY 2008 net costs relate to Medicare ($395.1 billion) and Health ($264.2 billion) programs, or nearly 93 percent of our annual costs. The table below depicts our net cost of operations by component for the last 5 years. The FY 2008 net cost represents an increase of $44.5 billion or 6.7 percent more than the FY 2007 net cost. Approximately 85 percent of the increase relates to Medicare, Medicaid, State Children's Health Insurance Program (SCHIP), and other health programs managed by the Centers for Medicare & Medicaid Services. More information on the Net Cost of Operations can be accessed at: http://www.hhs.gov/afr/2008sectioni.pdf

Net Cost of Operations *(Dollars in Billions)*	**FY 2004**	**FY 2005**	**FY 2006**	**FY 2007**	**FY 2008**	**Change**	**Percent Change**
Responsibility Segments							
Centers for Medicare & Medicaid (CMS) Gross Cost	$483.6	$521.7	$574.2	$612.4	$657.9	$45.5	7.4%
CMS Exchange Revenue	($32.0)	($38.1)	($49.8)	($50.3)	($54.0)	($3.7)	7.4%
CMS Net Cost of Operations	$451.6	$483.6	$524.4	$562.1	$603.9	$41.8	7.4%
Other Segments							
Other Segments Gross Cost of Operations	$97.8	$100.3	$102.2	$105.4	$108.3	$2.9	2.8%
Exchange Revenue	($2.2)	($2.6)	($2.7)	($2.9)	($3.1)	0.2	6.9%
Other Segments Net Cost of Operations	$95.6	$97.7	$99.5	$102.5	$105.2	$2.7	2.6%
Net Cost of Operations	**$547.2**	**$581.3**	**$623.9**	**$664.6**	**$709.1**	**$44.5**	**6.7%**

HHS Budget by Strategic Goal

The following table reflects an approximate full cost estimate of HHS funding by Strategic Goal and Objective for FY 2008. All dollar amounts are in billions. (Subtotals may not add due to rounding.)

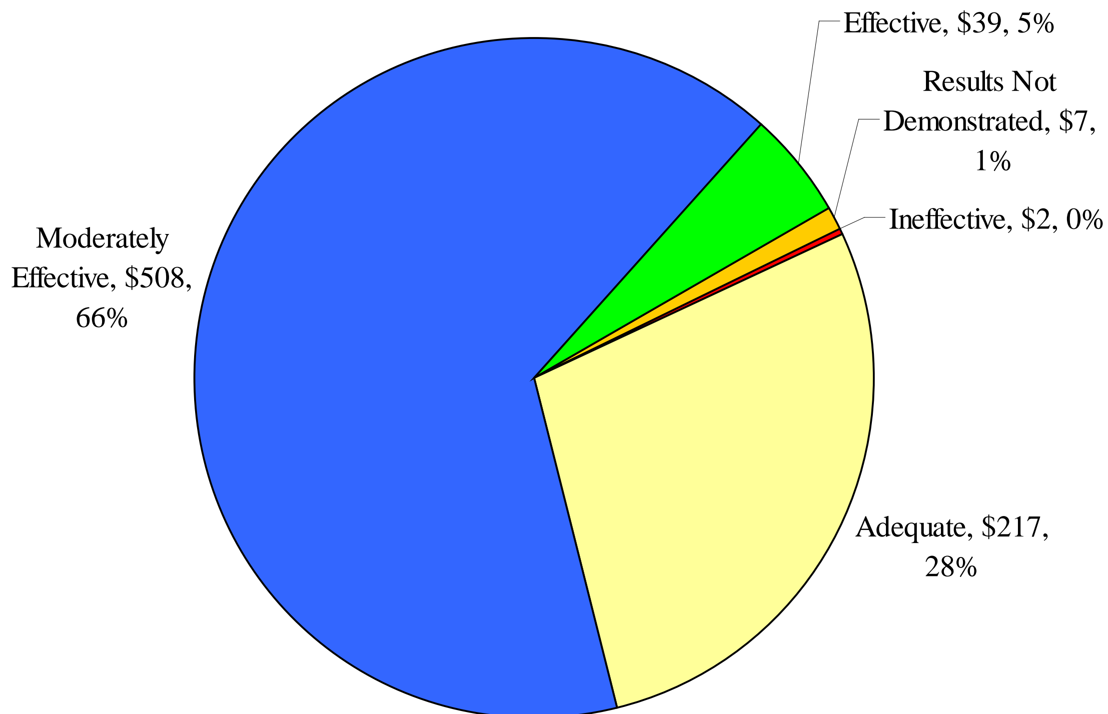
	FY 2008
Strategic Goal 1: Health Care - Improve the safety, quality, affordability and accessibility of health care, including behavioral health care and long-term care.	
1.1: Broaden health insurance and long-term care coverage.	$599.9
1.2: Increase health care service availability and accessibility.	$9.6
1.3: Improve health care quality, safety and cost/value.	$8.9
1.4: Recruit, develop, and retain a competent health care workforce.	$0.9
TOTAL	**$619.3**
Strategic Goal 2: Public Health Promotion and Protection, Disease Prevention, and Emergency Preparedness - Prevent and control disease, injury, illness and disability across the lifespan, and protect the public from infections, occupational, environmental and terrorist threats.	
2.1: Prevent the spread of infectious diseases.	$2.7
2.2: Protect the public against injuries and environmental threats.	$0.9
2.3: Promote and encourage preventive health care, including mental health, lifelong healthy behaviors and recovery.	$2.3
2.4: Prepare for and respond to natural and man-made disasters.	$2.1
TOTAL	**$8.0**
Strategic Goal 3: Human Services - Promote the economic and social well-being of individuals, families and communities.	
3.1: Promote the economic independence and social well-being of individuals and families across the lifespan.	$27.0
3.2: Protect the safety and foster the well-being of children and youth.	$13.7
3.3: Encourage the development of strong, healthy and supportive communities.	$2.9
3.4: Address the needs, strengths and abilities of vulnerable populations.	$1.1
TOTAL	**$44.6**
Strategic Goal 4: Scientific Research and Development - Advance scientific and biomedical research and development related to health and human services.	
4.1: Strengthen the pool of qualified health and behavioral science researchers.	$13
4.2: Increase basic scientific knowledge to improve human health and human development.	$14.3
4.3: Conduct and oversee applied research to improve health and well-being.	$11.5
4.4: Communicate and transfer research results into clinical, public health and human service practice.	$0.2
TOTAL	**$27.2**

Program Assessment Rating Tool (PART)

The Nation expects the projects and activities it funds to achieve results. The Program Assessment Rating Tool (PART), which was introduced in 2002, is used to assess program performance, design, management, and results. Programs receive ratings of Effective, Moderately Effective, Adequate, Ineffective, and Results Not Demonstrated (RND). HHS uses PART results to inform management and budget decisions throughout the year to improve program performance and efficiency. PART results are included each year in the Department's summer budget development process. Additionally, HHS ensures that programs use the PART to improve program performance, especially programs that received an RND rating.

Since 2002, all significant HHS programs, and 99 percent of HHS' budget, has been assessed through the PART process. Overall, programs representing nearly 97 percent of HHS' budget were rated Adequate or better. Most important, HHS also greatly reduced the number of programs for which results cannot be demonstrated – in other words, programs which lack adequate measures that would indicate whether or not they are effective. The chart below shows HHS' PART Ratings. For more detailed information on PART results for HHS programs, please see www.Expectmore.gov.

HHS PART Ratings (by Dollars in Billions)*



President's Management Agenda

As part of the President's Management Agenda, HHS participates in five government-wide and four program-specific initiatives with consistently high performance. The table below presents the Department's FY 2008 scorecard with a comparison to FY 2007. Overall, the Department finished FY 2008 with green progress ratings for all of the nine initiatives. HHS is committed to the President's Management Agenda goals and has made significant achievements on the scorecard relative to management excellence. For more information about the President's Management Agenda, visit http://www.hhs.gov/pma/.

It is noteworthy that during FY 2008, the Department improved two status scores, for the Performance Improvement and Health Information initiatives. Several progress ratings were also improved including those for the E-Government, Performance Improvement, and Faith-Based and Community initiatives. In FY 2008, key Department financial managers launched an unprecedented approach to improving financial performance. This approach consisted of a Department-wide effort to correct financial processes that ultimately lead to solid financial management. The success of this approach set the stage for the Department's Chief Financial Officer (CFO) community to develop a CFO Community Strategic Plan. This plan provides the foundation for the improvement of our financial performance and charts our course for the future.

A discussion of each initiative's progress during the past year can be found at www.hhs.gov/budget/09budget/2009BudgetInBrief.pdf.

President's Management Agenda Scorecard Results

		September 30, 2007		September 30, 2008	
Initiative Type	Target Area	Status	Progress	Status	Progress
Government-wide	Strategic Management of Human Capital	G	G	Y	G
	Commercial Services Management	G	G	G	G
	Financial Performance	R	G	R	G
	E-Government	Y	Y	Y	G
	Performance Improvement	R	Y	G	G
Program	Eliminating Improper Payments	Y	G	Y	G
	Faith-Based and Community Initiative	G	Y	G	G
	Real Property Asset Management	Y	G	Y	G
	Health Information	R	G	Y	G

Green

Successful Results

Yellow

Mixed Results

Red

Unsatisfactory Results

Department Management Challenges and High-Risk Areas

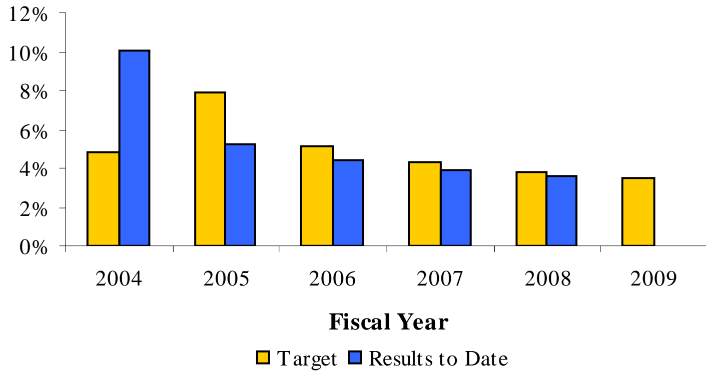
The scale, scope, and complexity of the activities administered by the Department results in several management challenges. The Office of the Inspector General (OIG) published management challenges on November 17, 2008, in the HHS FY 2008 Agency Financial Report. The Government Accountability Office (GAO) has placed three HHS programs on its "High Risk List," which lists programs that may have greater vulnerabilities to fraud, waste, abuse, and mismanagement, or programs that could benefit from broad-based transformations to address major economy, efficiency, or effectiveness challenges. See details on the actions to address issues in Medicare, Medicaid, and food safety. To ensure good stewardship of taxpayer resources, HHS is committed to efforts to make improvements related to these challenges and high-risk areas.

Management Challenge	Progress Assessment	Management Response	Future Plans
Oversight of Medicare Part D	CMS has demonstrated progress in: payment accuracy and internal controls; program safeguards; beneficiary protections.	CMS has made progress in its use of bid audits. MEDICs have not conducted data analysis to identify potential fraud. CMS has issued 9/18 chapters of the Prescription Drug Benefit Manual.	CMS will develop a centralized data repository to warehouse data on Medicare Parts A, B, D and Medicaid to provide a single source of information for CMS fraud, waste, and abuse activities.
Integrity of Medicare Payments	CMS has demonstrated vigilance in monitoring the gross paid claims error rate and is developing appropriate corrective action plans.	The CMS FY 2007 gross paid claims error rate of 3.9 percent is 6.2 percent lower than the FY 2004. CMS has made progress in its general and applicable controls and has begun implementing the Healthcare Integrated General Ledger Accounting System.	HHS will continue to address potential improper payment exposure for durable medical equipment under a 2-year effort aimed at stopping fraudulent billing to protect beneficiaries and taxpayers.
Appropriateness of Medicaid and SCHIP Payments	CMS has annually updated its 5-year Comprehensive Medicaid Integrity Plan to promote the proper expenditure of Medicaid fund, improve integrity performance, and foster collaboration with stakeholders.	The final Medicaid payment error rate is reported in the IPIA Report, included in the FY 2008 Agency Financial Report, Section III.	CMS plans to start educating providers on payment and billing integrity as well as quality-of-care issues related to personal care services in FY 2009. CMS is working to create a new database to store all State's Medicaid data.
Quality of Care	Progress continues to strengthen oversight of the quality of care paid for by the Medicare and Medicaid programs. CMS has promoted quality by collecting and publishing quality-related data on nursing homes and hospitals.	Progress continues to strengthen oversight of the quality of care paid for by the Medicare and Medicaid programs.	CMS plans to improve hospice oversight by improving the survey process and proposes to amend the hospice section of the State Operations Manual to enable State surveyors to make more consistent decisions regarding compliance with Medicare regulations.
Public Health and Medical Emergency Preparedness	States and localities are making progress in strengthening their bioterrorism preparedness programs. Federal, State and local health departments are striving to work cooperatively to ensure that potential bioterrorist attacks are detected early and responded to appropriately.	HHS issued an updated Purchase Card Guide and a 2-page Quick Reference Guide that highlights key information about emergency situations related to HHS purchase card policies and procedures.	CDC implemented stronger performance measures, which will continue to expand in future years, for the Public Health Emergency Preparedness cooperative agreement. Clearer guidance was developed for grantees to report on measures.
Oversight of Food, Drug, and Medical Device Safety	HHS has implemented many changes to protect human research subjects and to strengthen FDA and NIH oversight of scientific research. During FY 2008, FDA established offices in China to facilitate inspections of Chinese food and drugs before they are imported to the U.S.	As a major milestone in the globalization of efforts to enhance the safety of imported food and medical products, FDA announced plans to establish overseas offices in China, India, Europe and Latin American in 2008, with a fifth office in the Middle East in 2009.	FDA is developing an internal listing of all ongoing clinical trials as part of a broader effort to manage FDA's regulated product information electronically. FDA is also developing recommendations for improving the quality of its post-marketing study commitment processes.
Grants Management	HHS has worked to develop more consistent policies and practices, and has undertaken a leadership role in implementation of key legislation, along with the availability of grants funding opportunities via grants.gov.	AHRQ has established practices to ensure the integrity of grant data, timeliness of grantee reporting, and closeout procedures.	Emphasis is being placed on timely financial closeout of ended projects.
Integrity of IT Systems and the Implementation of Health IT	HHS has made progress in the security of its most critical and essential assets, such as laboratories, computer systems, and data communication networks. CMS has made progress in oversight of the HIPAA Security rules. ONC issued the ONC-coordinated Federal Health IT Strategic Plan, outlining two goals covering patient-focused health care and population health.	ONC is actively involved in several activities including the drafting of a privacy and security framework for electronic health information exchange and other supplemental materials. Significant progress also continues with collaborative initiatives involving state leadership and other stakeholders to address issues that have direct benefit to U.S. citizens, and cannot be resolved at the Federal level.	HHS plans to a privacy and security framework to increase trust among consumers and users of electronic individual health information and to govern all privacy and security efforts related to electronic health information exchange. In FY 2009, plans are to continue to develop best practices, tools, training and outreach mechanisms that could be built into existing initiatives.
Ethics Program Oversight and Enforcement	Both NIH and FDA have strengthened processes for reviewing outside activities. Additionally, the OGC Ethics Division continues to expand its ethics program oversight, guidance and training activities.	HHS continued program reviews at NIH and other components. The Program Review Section, uncovered significant vulnerabilities in a number of component ethics programs and has issued formal reports this year containing recommendations for improvement.	The OGC Ethics Division is planning to issue a package with waiver guidance and information regarding delegation of authority to issue waivers. The Ethics Division oversees component ethics program operations, including the review of waivers.

Appendix of Linked HHS Strategic Plan Measures

Strategic Objective 1.1: Broaden health insurance and long-term care coverage.

Measure: Reduce the percentage of improper payments made under the Medicare fee-for-service (FFS) program.



The Centers for Medicare & Medicaid Services' (CMS) Medicare Integrity Program (MIP) safeguards 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: The improper payment rate measures the percentage of payment dollars that are overpayments or underpayments. This rate is estimated based on data from the two Medicare fee-for-service (FFS) measurement programs: the Comprehensive Error Rate Testing (CERT) program and the Hospital Payment Monitoring Program (HPMP).

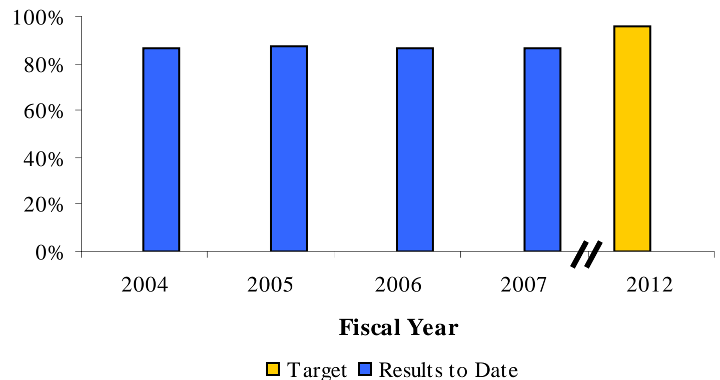
The FY 2008 rate of 3.6 percent was better than the FY 2008 target of 3.8 percent. To strengthen our confidence in the CERT review findings and assure the accuracy of reported error rates, CMS began an effort to independently perform blind, random reviews of its CERT review contractor's payment determinations starting with the FY 2008 measurement. At the time of this report publication, the results of those reviews were incomplete.

The improper payment rate has already been reduced substantially, and therefore CMS will need targeted strategies to achieve further reductions. CMS will pursue strategies directed at specific regions, providers, and error types. These strategies include developing new data analysis procedures to identify payment aberrancies and using that information to preemptively stop improper payments. CMS will also direct Medicare contractors to develop local efforts to lower the improper payment rate by creating plans that address the problems the root causes of errors.

Data Source: The data for this measure is from CMS' CERT and HPMP programs.

Measure: Increase the number of persons (all ages) with access to a source of ongoing care.

The Health Resources and Services Administration (HRSA) is one of the principal Federal agencies charged with improving access to health care for people who are uninsured, isolated, or medically vulnerable. HRSA programs provide access to a variety of health care services, particularly targeting vulnerable and underserved populations.



Performance: Healthy People 2010 and the HHS Strategic Plan established a long-term goal to ensure that 96 percent of all people have access to a source of ongoing care by 2012. In 2007, 86.5 percent of the Nations population (age-adjusted) had access to a source of ongoing care. This was a slight improvement from 86.2 percent in 2006. During this decade, the figure has fluctuated between 86 percent and 88 percent. As a long-term goal, there are no annual targets for this measure.

The long-term perspective on this National goal encourages collaboration at the Federal, State and local levels. Any progress toward the 2012 target may be attributed to many factors, including growth in the number of persons served by HRSA's Health Centers Program which provides "health homes" for millions of persons who would otherwise lack access to needed care.

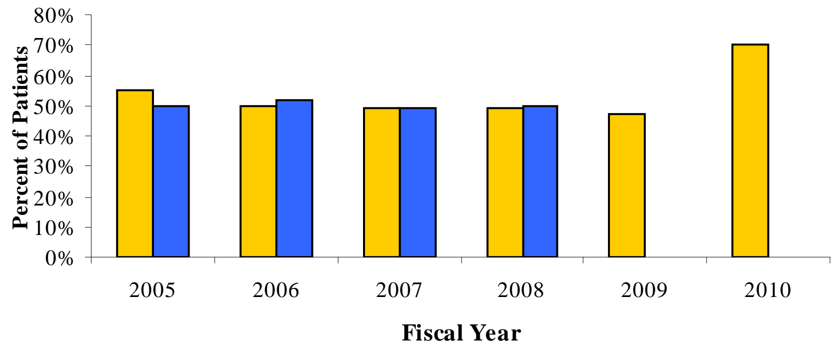
One challenge to achieving the goal of ensuring access to a source of ongoing care to 96 percent of all people is that nearly 45.7 million individuals do not have health insurance. These individuals are far more likely than those with insurance to report problems in getting needed medical care. Other challenges include poverty, homelessness, language barriers, geographic isolation, and lack of affordable transportation options. HRSA's Health Centers Program addresses financial and other types of barriers to care in providing regular access to comprehensive, high-quality primary and preventive health care through more than 1,000 health centers and approximately 7,000 service delivery sites in rural and urban areas. The number of patients served by Health Centers is expected to rise to 16.85 million patients in 2009, among which will be nearly seven million uninsured individuals. HRSA also continues to provide national leadership in the development, distribution, and retention of a diverse, culturally-competent health workforce, including investments in the National Health Service Corps, which helps to reach individuals in underserved areas.

Data Source: The data for this measure is from the National Health Interview Survey, conducted by the Centers for Disease Control and Prevention.

Measure: Increase the proportion of (1) American Indian and Alaska Native patients with diagnosed diabetes who receive an annual retinal examination; and (2) Increase the proportion of eligible American Indian and Alaska Native patients who have had appropriate colorectal cancer screening.

Expanding access to health screenings for American Indians and Alaska Natives (AI/AN) is a collaborative effort between the Indian Health Service (IHS) and Tribes in order to prevent and reduce the complications of chronic disease and promote improved health. Early detection of diabetic retinopathy (DR) is a fundamental and critical part of the effort to reduce visual loss among people with diabetes. Research also shows that appropriate screening for colorectal cancer may reduce colorectal cancer mortality by 33.4 percent.

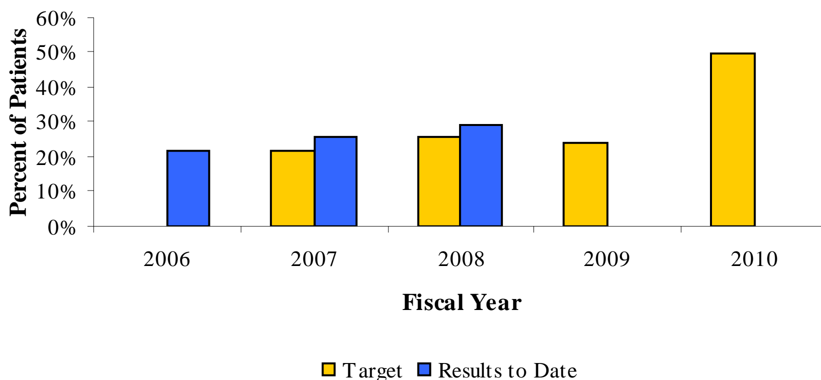
American Indians and Alaskan Natives with Diagnosed Diabetes Who Receive Annual Retinal Examinations



Performance: This measure changed in FY 2006 from reporting DR screening rates of Tele-ophthalmology demonstration sites to reporting the rate of all sites, regardless of the type or use of technology. In FY 2007, IHS met the target for the number of patients who received annual retinal examinations. In FY 2008, IHS exceeded the target of 49 percent . The target in FY 2009 is 47 percent because IHS will face challenges in DR screening such as increased medical inflation. The Indian Health Service will continue to improve performance through heightened attention to DR, disseminating best practices of high performing sites, and continued expansion of the IHS-Joslin Vision Network tele-ophthalmology program.

In FY 2006, IHS added colorectal cancer screening as a performance measure with a baseline rate of 22 percent. During FY 2007, 26 percent of eligible patients received colorectal cancer screenings, an increase of four percent over the target. In FY 2008 IHS exceeded its target and screening rates increased to 29 percent. This result was attained because IHS targeted the potential impact of colorectal screening to reduce mortality rates and health care costs when the most effective treatments can begin at the earliest, localized stage. The FY 2009 performance target of 27 percent reflects a two percent decrease because colorectal cancer screening remains a high-cost procedure that often cannot be provided within the IHS system. In addition to financial challenges, the AI/AN sector of the baby boomer population continues to grow similarly to the U.S. population, leading to an increase in the number of patients eligible for screening.

Eligible American Indians and Alaskan Natives with Diagnosed Diabetes Who Have Had Appropriate Colorectal Cancer Screening



Data Source: The data for this measure is from the IHS Clinical Reporting System (CRS application).

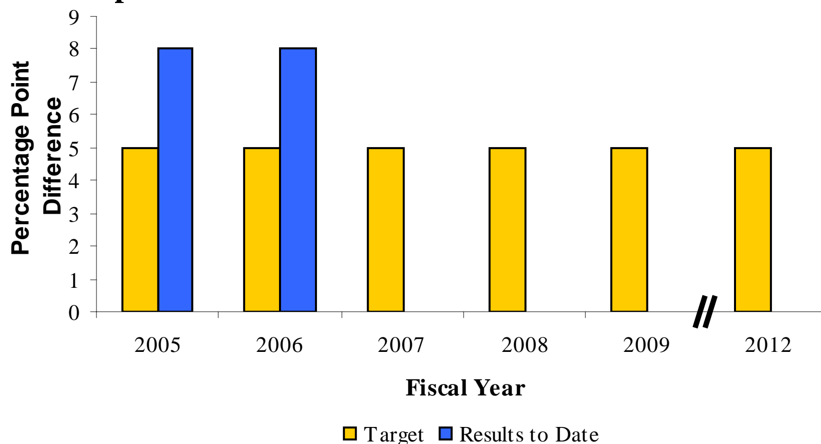
Measure: Serve the proportion of racial/ethnic minorities in programs funded through the Ryan White HIV/AIDS Program at a rate that exceeds their representation in national AIDS prevalence data.

The Ryan White HIV/AIDS Treatment Modernization Act of 2006 (Ryan White HIV/AIDS Program) addresses the unmet care and treatment needs of persons living with HIV/AIDS who are uninsured or underinsured. Ryan White HIV/AIDS Program funding, to governmental, community-based and other non-profit organizations, pays for core primary health care and support services that enhance access to and retention in care and fills gaps in care not covered by other resources or payers.

Performance: In pursuing its mission, the Ryan White HIV/AIDS Program works to provide access to HIV/AIDS treatment for those disproportionately impacted by HIV/AIDS such as racial and ethnic minorities. By serving a proportion of racial/ethnic minorities that exceeds their representation in national AIDS prevalence data as reported by the Centers for Disease Control and Prevention (CDC), the Ryan White HIV/AIDS Program demonstrates its effectiveness in actively identifying and reaching out to persons who data indicate have substantial unmet care and treatment needs.

In 2006, 72 percent of Ryan White HIV/AIDS Program clients were racial/ethnic minorities. This is a significantly higher proportion than their representation (64 percent) among CDC-reported AIDS cases. This result exceeds the target of serving a proportion of minorities that is five percentage points above the CDC data. The target for future years continues to be to serve a proportion of racial/ethnic minorities that is five percentage points above the CDC-reported AIDS prevalence data for each year.

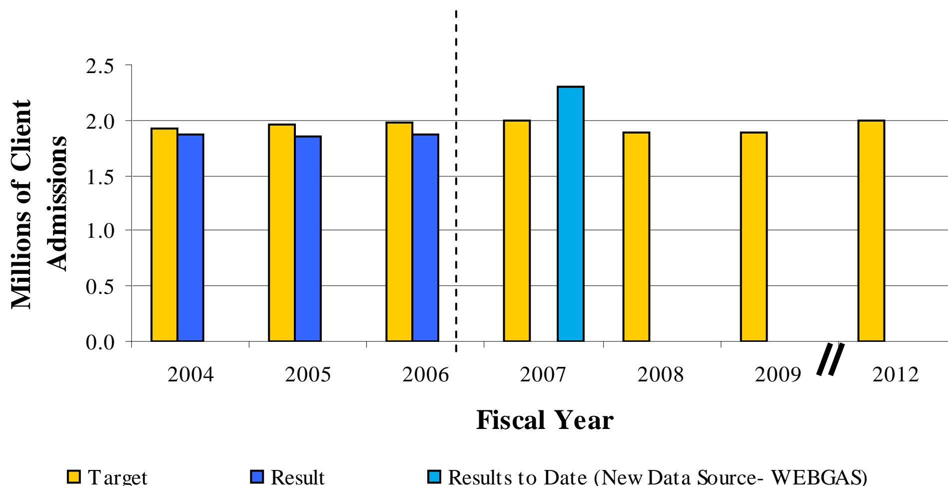
The Program strives to address disparities in access to essential services for racial/ethnic minorities while also providing needed services to eligible persons in non-minority racial/ethnic groups. Ongoing challenges in meeting the performance target include the following: many persons are unaware of their serostatus; persons who know they are infected may be reluctant to seek HIV/AIDS care; and persons may be unaware of the availability of Ryan White HIV/AIDS Program services. Strategies that providers have adopted to address these challenges include testing; use of targeted outreach models designed to reach racial/ethnic minorities not engaged in clinical care and link them to appropriate clinical, supportive, and preventive services; and follow-up activities designed for high-risk groups.



Data source: The data for this measure is from HRSA's Ryan White HIV/AIDS Program and the Centers for Disease Control and Prevention.

Measure: Increase the number of client admissions to substance abuse treatment programs receiving public funding.

The Substance Abuse Prevention and Treatment Block Grant provides funding to States to plan, carry out, and evaluate activities to prevent and treat substance abuse.

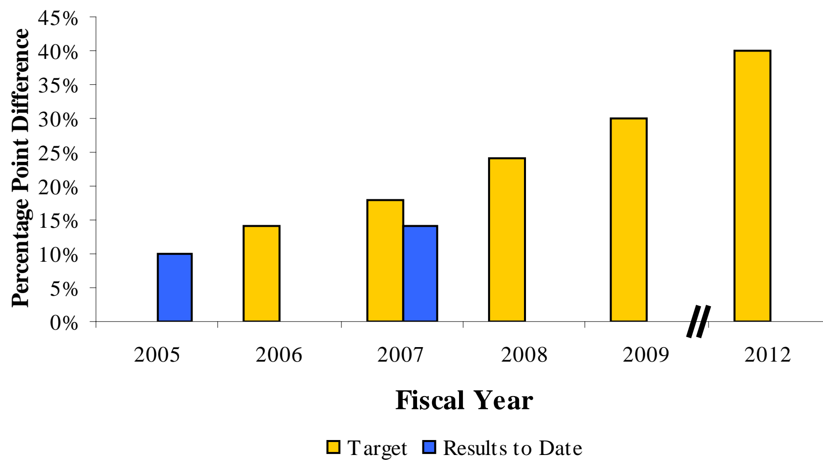


Performance: The number of client admissions to substance abuse treatment programs remained slightly below 1.9 million from FY 2002 through FY 2006. Modest fluctuations in the number of client admissions in these years can be attributed to changes in the number of treatment facilities in operation in the States. The number of client admissions in FY 2006 was slightly above the number of admissions in the prior year, and was six percent below the target set for FY 2006. The decrease in the FY 2008 and FY 2009 targets shown in the table below is associated with a decrease in the number of providers, which resulted from increased costs of doing business and relative decreases in the availability of resources. Data is not yet available for FY 2007 or FY 2008, as there is a data lag of approximately two years associated with data collection and analysis.

For FY 2009, the target is slightly below 1.9 million client admissions, an increase of one percent over the most recent performance result. For the longer term, a target has been established to achieve 2.0 million client admissions by FY 2013, representing an eight percent increase over the most recent performance result.
The Substance Abuse and Mental Health Services Administration (SAMHSA), which administers the Substance Abuse Prevention and Treatment Block Grant, is working in collaboration with critical stakeholders to disseminate important innovations to improve the availability and cost effectiveness of services. SAMHSA is also working with its partner agencies at the National Institutes of Health to disseminate evidence-based practices related to improving access and reducing overall treatment costs.

Data Source: The data for this measure comes from the Treatment Episode Data Set component of the SAMHSA Drug and Alcohol Services Information System, and has a two year data lag. Additional information can be found at http://oas.samhsa.gov/dasis.htm#teds2.

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



The Office of the National Coordinator for Health Information Technology (ONC) executes the necessary strategic planning, coordination, and analysis related to the public and private adoption of health information technology (IT).

Performance: The President called for most Americans to have access to EHRs by the year 2014. Health IT is a critical component in improving the quality, safety, cost and value of health care offered to our Nation's 300 million Americans. To further the ability of health IT to improve the quality and efficiency of services, the Centers for Medicare & Medicaid Services (CMS) executed a demonstration project in FY 2008 to provide financial incentives for physician practices to adopt certified EHR systems.

To measure progress towards the President's goal, ONC tracks physician adoption of EHRs. Data from FY 2005 established a baseline of 10 percent of physicians adopting EHRs. The target for FY 2006 was 14 percent of physicians adopting EHRs, but no survey was conducted that year, and consequently, no data is available. For FY 2007, data shows that 14 percent of physicians have adopted EHRs. ONC is identifying and analyzing the factors that pose barriers for physicians to adopt EHRs. By FY 2009, ONC expects that the physician adoption rate will increase to 30 percent. Actions of other HHS entities that collaborate with ONC could affect the physician adoption rate. For instance, the CMS EHR demonstration could affect the adoption rate among small to medium-sized practices. Also, beginning in FY 2009, programs that promote the workforce development for health IT products and educate the public on health IT may positively influence adoption rates.

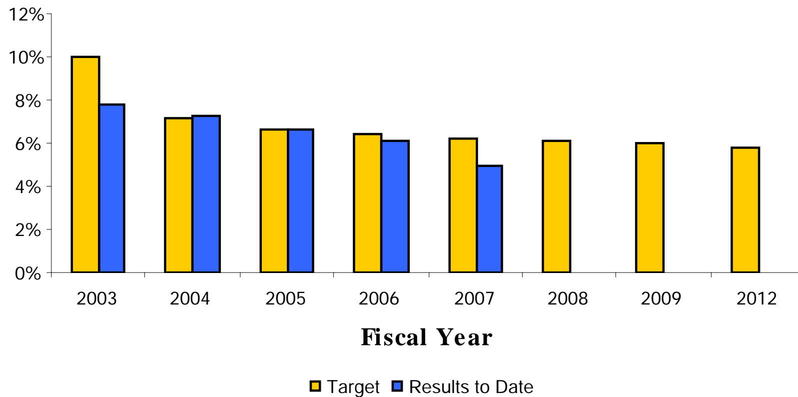
ONC faces programmatic and management challenges in addressing the multiple barriers that physicians confront in transitioning from paper to electronic medical records. ONC is coordinating with its Federal partners to address these challenges. For instance, ONC and its Federal partners worked to eliminate legal barriers posed by Stark and anti-kickback laws that prevent hospitals from financially contributing towards a physician's purchase of certified EHRs. In addition, ONC is ensuring that certification of health IT products includes the criteria necessary for state of the art interoperability to encourage physicians to buy certified EHR products. ONC is also working with malpractice insurers to potentially lower malpractice insurance premiums for physicians who have adopted certified EHRs.

Data Source: This final data is obtained from the Centers for Disease Control and Prevention (CDC) National Ambulatory Medical Care Survey. FY 2008 data will be available in February 2009.

Measure: Decrease the prevalence of restraints in nursing homes.

Medicare finances health insurance for eligible elderly and disabled individuals. The Centers for Medicare & Medicaid Services' (CMS) Nursing Home Quality Initiative is a comprehensive strategy to improve quality of care in nursing homes, which includes continuing regulatory and enforcement systems. In addition, community-based nursing home quality improvement programs, and collaborative efforts to promote awareness and support, are underway.

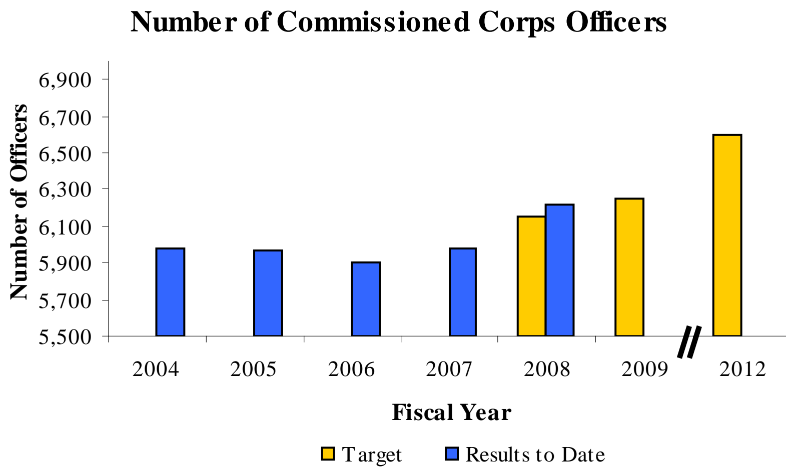
Performance: The prevalence of physical restraints is an accepted indicator of quality of care in nursing homes, and their use has declined dramatically from the 1996 baseline of 17.2 percent. CMS met its FY 2005 target of 6.6 percent. In FYs 2006 and 2007, CMS exceeded its targets of 6.4 percent and 6.2 percent with actual rates of 6.1 and 5.0 percent, respectively. As a result of the reduction in restraints from FY 2006 to FY 2007, about 15,000 fewer nursing home residents are restrained each day. This recent success can be attributed to CMS' major quality initiatives, through CMS annual surveys, efforts of the Quality Improvement Organizations, and the national campaign entitled *Advancing Excellence in Nursing Homes*.



CMS will be challenged to continue to decrease the prevalence of restraints. While CMS has made significant progress, the slower rate of decline in the prevalence of physical restraints in nursing homes 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.

Data Source: The data for this measure is from CMS' Minimum Data Set-Quality. There is a data lag such that results for FY 2008 will not be available until March 2009.

Measure: Increase the number of Commissioned Corps Officers.



The Commissioned Corps of the U.S. Public Health Service is a key HHS asset to support both its core public health and emergency response missions. To improve the Corps' capacity and ability to fulfill these missions, it is critical that the active duty force strength be increased.

Performance: The Corps total force strength has been relatively constant for over a decade; however, the expanded goals for the Corps (as outlined in the October 2006 Secretarial Transformation Implementation Plan[1]) call for a greater number of officers to meet the Corps' obligations. The Secretary directed the Corps to increase the size of the force by 10 percent to 6,600 officers by 2012. The FY 2008 target was 6,150. The Corp exceeded this target – by the end of the fiscal year there were 6,215 officers, which represented the highest level of the Corps in over 10 years. Under the Transformation Plan the Division of Commissioned Corps Assignments was reorganized to streamline and improve the efficiency of the recruitment/accessions process. The number of cleared applicants tripled. Future plans include continuing to increase our operational efficiency and creating new programs and partnerships to grow the Corps' workforce strength and meet future HHS growth targets.

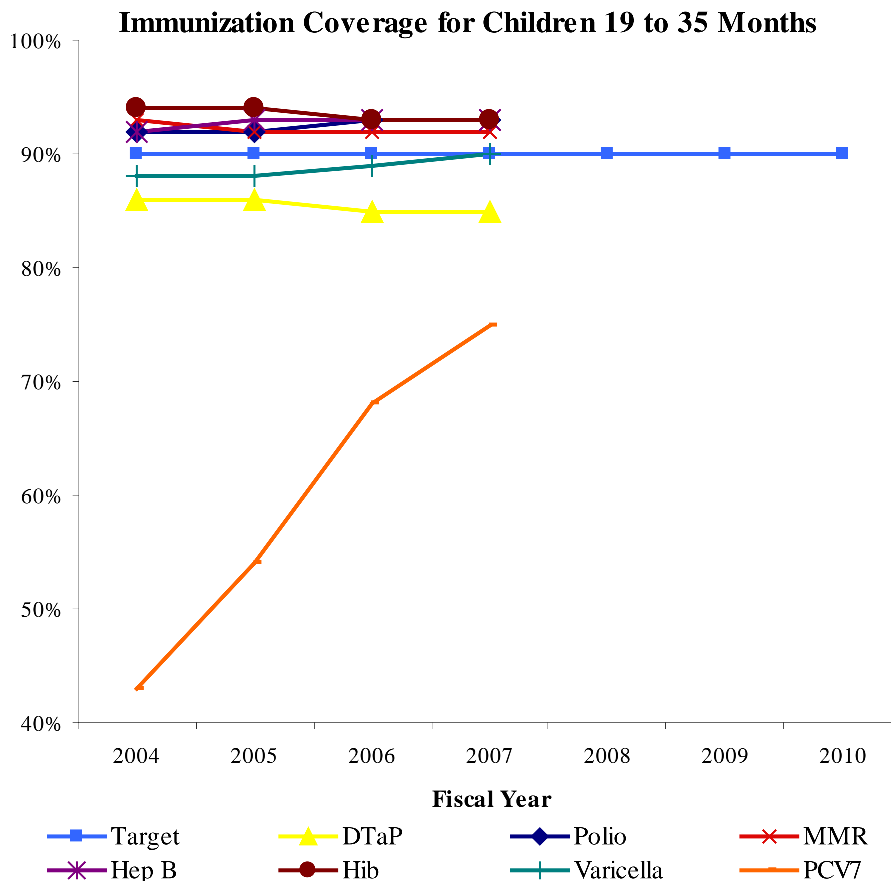
Commissioned Corps physicians and dentists have declined in number over the last few years. This outcome is similar to that seen in other public sector systems and is due to remuneration factors, increasing retirement eligibility and other factors. In response, we have created a new pilot program to provide incentives for physicians to join the Corps and have also established an accession bonus to increase the recruitment of dentists. We have also proposed establishing initial loan repayment and scholarship programs in the FY 2009 Presidents Budget. These efforts, if approved, will help the Corps to ameliorate these current trends and enable us to continue to meet the HHS workforce growth targets.

Data Source: http://dcp.psc.gov/rpt_select.asp

[1] http://dcp.psc.gov/PDF_docs/Commissioned_Corps_Transformation_Implementation_Plan.pdf

Strategic Objective 2.1: Prevent the spread of infectious disease.

Measure: Achieve or sustain immunization coverage of at least 90% in children 19 to 35 months of age for: a) 4 doses of Diphtheria-Tetanus-Pertussis (DtaP) vaccine; b) 3 doses of polio vaccine; c) 1 dose of Measles-Mumps-Rubella (MMR) vaccine; d) 3 doses of hepatitis B vaccine; e) 3 doses of Haemophilus influenzae type b (Hib) vaccine; f) 1 dose of varicella vaccine; and g) 4 doses of pneumococcal conjugate vaccine (PCV7).



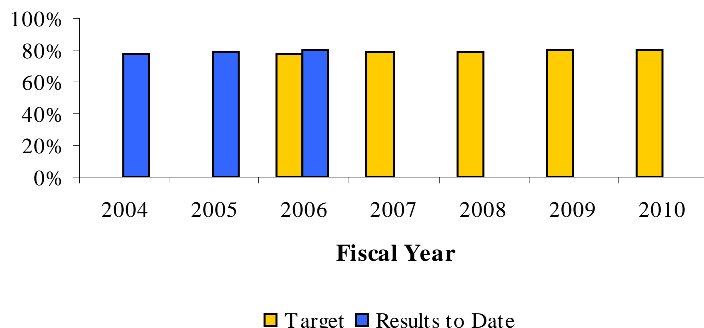
The Childhood Immunization Program through Centers for Disease Control and Prevention (CDC) aims to prevent disease, disability and death in children and adults through vaccination by providing grants to State and local health departments to purchase vaccines and conduct immunization programs.

Performance: Vaccinations protect individuals, and through "herd immunity," vaccinations also protect communities. Maintenance of high vaccination coverage levels in early childhood is the best way to prevent the spread of vaccine preventable diseases. In general, vaccination coverage levels of 90 percent are sufficient to prevent circulation of viruses and bacteria-causing diseases. Ninety percent coverage was met in FY 2007 for most vaccines with the exception of PCV7 and the fourth dose of DTaP. A notable achievement includes varicella coverage recently reaching the target, with rates rising from 43 percent in FY 1998 to 90 percent in FY 2007. Because antibiotic resistance is making pneumococcal infections difficult to treat, the prevention of pneumococcal infections with PCV7 is becoming more important. Vaccination coverage with four doses of PCV7 was reported for the first time in 2006 at 68 percent; coverage improved seven points to 75 percent in FY 2007. Reaching 90 percent coverage for the fourth dose of the DTaP vaccine has also been difficult to achieve because the fourth dose vaccine requires a specific visit to the doctor and does not coincide with regular well-baby visits as the first three doses do.

Routine childhood vaccination as part of the childhood immunization schedule prevents nearly 14 million disease cases and 33,000 deaths over the lifetime of children born in any given year and has resulted in annual savings of $9.9 billion in direct medical costs and an additional $33.4 billion in indirect savings. Each year, the program must both ensure the vaccination of newly-born children and ensure that all children are vaccinated for any new vaccines added to the schedule. Nearly one million two-year olds in the U.S. have not received one or more of the recommended vaccines. Coverage levels for immunized children by age two are high nationally. In many States, however, pockets of need, or areas where substantial numbers of under-immunized children reside, challenges continue and coverage in these areas is below the 90 percent target.

Data Source: The data for this measure is from the National Immunization Survey and has a one-year data lag.

Measure: Increase the proportion of people with HIV diagnosed before progression to AIDS.



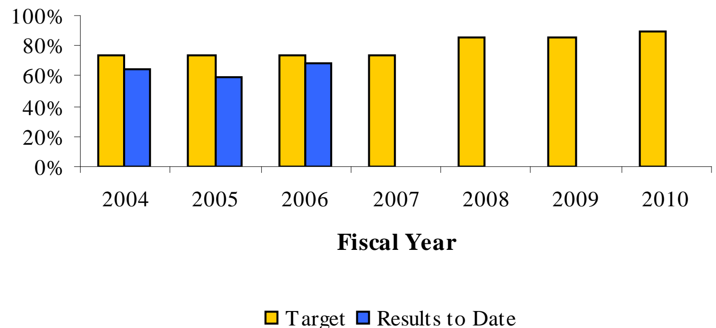
Since the mid-1990s, effective medical therapies for both HIV infections and associated infections that develop because of weakened immune systems have dramatically reduced death rates associated with HIV. Age-adjusted mortality due to HIV disease declined from approximately 17 per 100,000 population in 1995 to less than six per 100,000 population in 2002. However, to take advantage of effective, life-preserving therapies and to prevent transmission of HIV to others, HIV-infected individuals should be aware of their infection early in the course of the disease. The Centers for Disease Control and Prevention (CDC) provides funding and technical assistance to 65 State and local health departments to conduct HIV/AIDS prevention programs aimed at preventing HIV infection and increasing early diagnosis.

Performance: In FY 2006, the most recent year for which data are available, the proportion of persons with HIV infection diagnosed before progression to AIDS increased from the previous year to 79.7 percent, exceeding the 78 percent target. Prior year trends demonstrate slight increases in this measure over time, reflecting in part the emphasis CDC is placing on HIV testing and knowledge of serostatus. The proportion of persons with HIV infections diagnosed before progression to AIDS increased slightly from 78.1 percent in FY 2004 to 78.8 percent in FY 2005.
These figures are based on the most recent data available, and include updates to prior year's performance for 2004 – 2005. This data was revised in 2007.
Denial about HIV may be one reason why HIV-infected individuals do not get tested. Issues such as substance abuse (including injection drug use), mental health problems, childhood sexual abuse, and other psychological stressors may make it difficult for people to place importance on HIV testing. In addition, persons with HIV have historically had less access to medical care and have a higher rate of conditions, such as gonorrhea and syphilis, known to elevate risk of HIV transmission. Finally, the stigma related to an HIV diagnosis may cause people to avoid getting tested for HIV or to avoid medical care because their HIV infection may become known and lead to rejection by family members, friends, and coworkers.
CDC continues to promote early diagnosis through HIV testing and screening. The agency issued revised recommendations for HIV testing in medical care settings in 2006 and, in 2007, funded an initiative to promote increased testing in jurisdictions with the highest rates of disease among African Americans. In FY 2008, CDC continued to work with providers to encourage the uptake of its screening guidelines. CDC also allocated funds to six jurisdictions with HIV testing policies specified in section 209 of the Ryan White HIV/AIDS Treatment Modernization Act of 2006. In 2009, CDC will continue to work with insurers and medical care providers to increase the uptake of its HIV screening recommendations and will encourage its grantees to continue to emphasize HIV testing.

Data Source: Data for this measure is from the HIV/AIDS Reporting System and has a two-year data lag.

Measure: Increase the rate of influenza vaccination: a) In persons 65 years of age and older; and b) Among noninstitutionalized adults at high risk, aged 18 to 64.

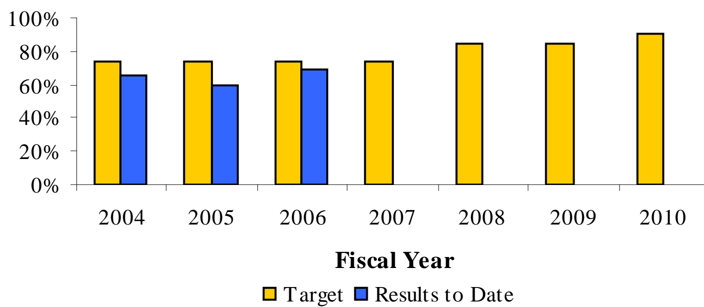
The Centers for Disease Control and Prevention's (CDC) immunization program supports the Advisory Council for Immunization Practice's (ACIP) recommendations for influenza vaccination.



Performance: Vaccination coverage levels of 90 percent are sufficient to prevent circulation of viruses and bacteria-causing illnesses. Thus, a high percentage of a population at-risk for a vaccine-preventable illness should receive the vaccine. For adults at high risk for influenza, the ACIP Recommended Adult Immunization Schedule recommends annual influenza and pneumococcal vaccination.

During the past decade, influenza vaccination coverage levels among older adults increased steadily as CDC implemented national strategies and promoted adult and adolescent immunization among health care providers and state and local health departments. However, in FY 2005, coverage decreased to 60 percent, and was likely related to unprecedented shortages of influenza vaccination in the 2004-2005 season and delays of influenza vaccinations in the 2005-2006 seasons. In FY 2006, the most recent year for which data is available, influenza vaccination levels among the elderly increased to 69 percent, consistent with increases from 30 percent in FY 1989 to 65 percent in FY 2004. Due to an anticipated increase in vaccine promotion among the elderly, the FY 2008/2009 goals were raised to 85 percent.

A decrease in influenza vaccine coverage was also seen in FY 2005 for the high-risk 18 to 64 year-old population. High-risk adults aged 18 to 64 years may not have insurance coverage for influenza vaccines, may make fewer visits for preventive care, and may not recognize influenza vaccination recommendations. Persons with high-risk conditions, such as heart disease and diabetes, remain at increased risk from these diseases.



Adult vaccination rates are slowly increasing. CDC has worked with the Centers for Medicaid and Medicare Services to raise the reimbursement rate for healthcare providers for influenza vaccines. It is likely that issues with vaccine availability, distribution, and recognition of priority group recommendation affected coverage status. CDC will work with partner groups to increase awareness of influenza and pneumococcal vaccination recommendations.

Data Source: The data for this measure is from the National Health Interview Survey. Data for FY 2007 will be available in January 2009.

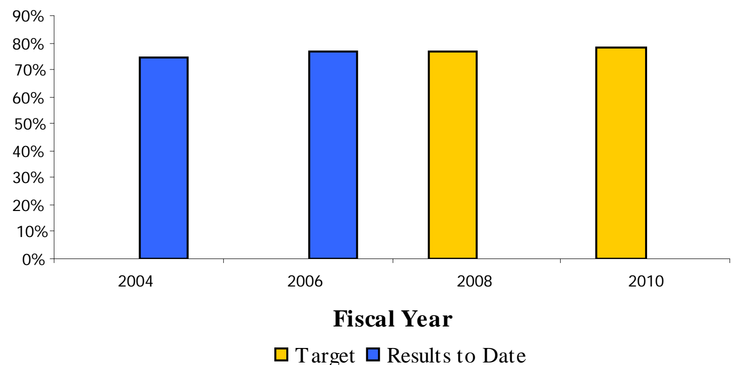
Strategic Objective 2.3: Promote and encourage preventive health care, including mental health, lifelong health behaviors, and recovery.

Measure: Increase the proportion of women aged 40 years and older who have received a mammogram within the preceding 2 years.

The Centers for Disease Control and Prevention's (CDC) National Breast and Cervical Cancer Early Detection Program (NBCCEDP) provides free or low-cost breast and cervical cancer screening and diagnosis to low-income, uninsured, and underinsured women.

Performance: Timely mammography screening among women aged 40 years or older is the best available method to detect breast cancer in its earliest, most treatable stage, and could reduce breast cancer mortality by approximately 16 to 30 percent compared with women who are not screened. In FY 2004, the baseline year for this measure, the percentage of women 40 years or older who received a mammogram within the prior two years was 74.6 percent.[1] In FY 2006, the most recent year for which data are available, the percentage of women who received mammograms increased to 76.6 percent, demonstrating considerable progress toward achieving the FY 2008 target of 77 percent.
The national screening program has contributed to the notable decline, in recent years, in breast and cervical cancer deaths by providing access to screening services, increasing breast and cervical cancer awareness and education, and inherently changing health-seeking behaviors in women for whom screening services are not otherwise available or accessible. Nationwide cancer screening measures, including mammography, vary for a number of reasons, such as publication of national guidelines, Medicare benefits, passage of State legislation on private insurance coverage, physician recommendations, cancer awareness and education, general health-seeking behaviors, and other social and economic factors, such as access and affordability. CDC provides services only to low-income, uninsured, and underinsured women. The program is able to reach 15 percent of eligible women 40 years or older. In 2007, the NBCCEDP screened 295,338 women for breast cancer and detected 3,962 breast cancers. The population served was about one-half of one percent of the total population of women age 40 years or older in the United States. CDC aims to increase the percentage of mammograms in women 40 years or older to 78 percent in FY 2010. Based on increasing annual rates in the 1990s, and the recent slowing of these increases in mammography use since the late 1990s, these projected increases will be challenging, yet achievable.

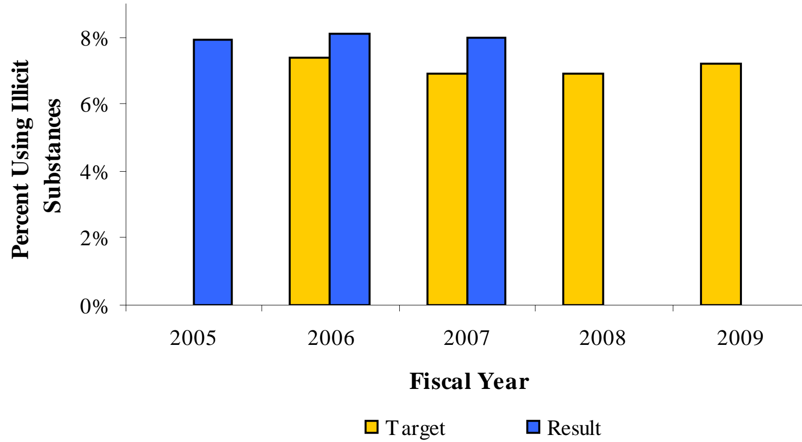
Proportion of Women Aged 40 years and Older Who Have Received a Mammogram within the Preceding 2 Years



Data Source: The data for this measure is from the Behavioral Risk Factor Surveillance System and is collected every other year. Data for FY 2008 will be available February 2010.

[1] CDC does not report in odd years, as data for this measure is in the Women's Health section of the Behavioral Risk Factor Surveillance System, which is an optional "Module" in odd years.

Measure: Reduce 30-day use of illicit substances (age 12 and older).



The Substance Abuse and Mental Health Services Administration (SAMHSA) awards Strategic Prevention Framework grants to build the capacity of States, Tribes, Territories, and communities to decrease substance use and abuse and promote behavioral health. SAMHSA also administers a formula grant to States and conducts numerous other activities targeted at reducing substance use and its associated consequences.

Performance: The percentage of individuals age 12 and over who report having used an illicit drug within the previous 30 days improved slightly from 2002 (8.3 percent) to 2007 (8.0 percent), the most recent year for which data is available. The 2007 target of 6.9 percent was not met, as national substance abuse rates are influenced by many factors, including the emergence of new drugs of abuse and demographic and economic trends. However, among adolescents ages 12 to 17, the rate of use fell from 11.6 percent to 9.5 percent, reflecting the success of prevention efforts such as the SAMHSA Strategic Prevention Framework.

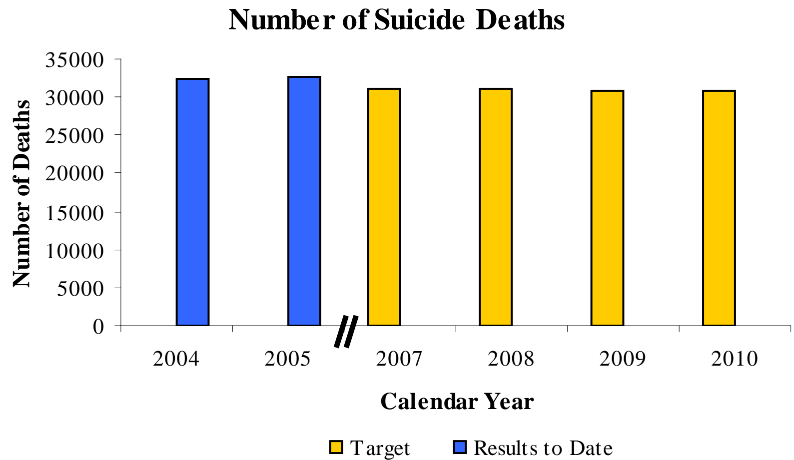
In 2007 HHS established the ambitious goal of reducing the rate of illicit drug use to 5.8 percent by 2012. In order to achieve this goal, a target has been established to reduce illicit drug use to 6.9 percent by 2009.

In pursuit of continual reductions in illicit drug use, SAMHSA has implemented an automated data collection and reporting system that will provide administrators, policy-makers, and practitioners with feedback on their prevention efforts, enabling them to modify their initiatives to address realities on the ground.

Data Source: The data for this measure is from the SAMHSA National Survey on Drug Use and Health, which has a one year data lag. Additional information on NSDUH is available at http://oas.samhsa.gov/nsduhLatest.htm.

Measure: Reduce the number of suicide deaths.

The Substance Abuse and Mental Health Services Administration (SAMHSA) administers suicide prevention grants to campus, State, and Tribal organizations (as authorized by the Garrett Lee Smith Memorial Act); a Suicide Prevention Hotline; a Suicide Prevention Resource Center; and an American Indian/Alaska Native Suicide Prevention initiative. These efforts address some of the risk factors which contribute to suicide being the 11th leading cause of death in the United States.



Performance: The number of suicide deaths in the United States has steadily increased from 29,199 in 1999 to 32,637 in 2005. This represents an increase in the rate of suicide deaths from 10.5 to 11.0 per 100,000 people. In order to address this increasing trend, in 2007 HHS established the ambitious goal of reducing suicide deaths by six percent by 2012.

Using 2004 as the baseline, the first annual target for this newly established performance measure is to reduce suicide deaths from 32,439 to 31,084 in 2007. Results for 2007 will be available in 2010, after the requisite data has been compiled from death certificates filed with State vital-statistics offices.

To reduce the number of suicide deaths each year, SAMHSA works through programs that focus on suicide prevention across the lifespan, as well as through programs focused on youth suicide prevention. The Suicide Prevention Resource Center provides prevention support, training, and resources to assist organizations and individuals to develop suicide prevention programs, interventions and policies. The National Suicide Prevention Lifeline provides 24-hour, toll-free telephone access to a network of certified local crisis centers available to anyone in suicidal crisis.

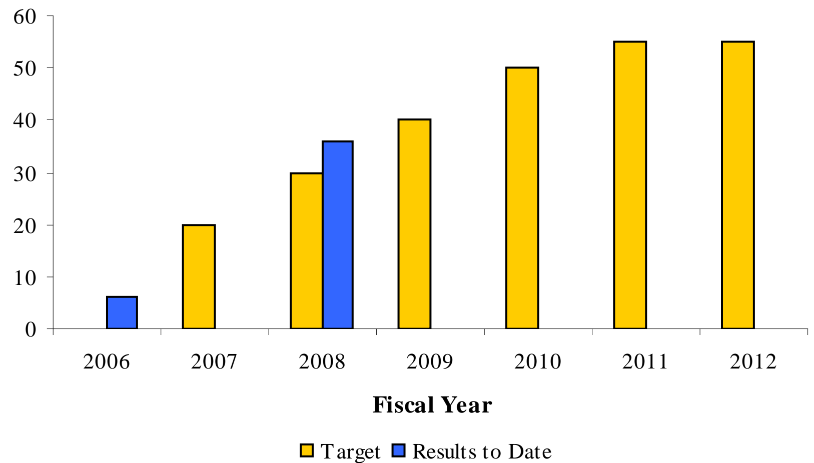
To address youth suicide, SAMHSA will continue to support grants to States, Tribal organizations, and institutions of higher education to enhance services for students with mental and behavioral health problems that may lead to school failure, depression, substance abuse, and suicide attempts.

Data Source: This data is from CDC's National Vital Statistics Report, and has a three year data lag. Additional information about this report can be found at http://www.cdc.gov/nchs/products/pubs/pubd/nvsr/nvsr.htm.

Strategic Objective 2.4: Prepare for and respond to natural and man-made disasters.

Measure: Increase the number of States and territories that include persons with disabilities in emergency management plans and responses.

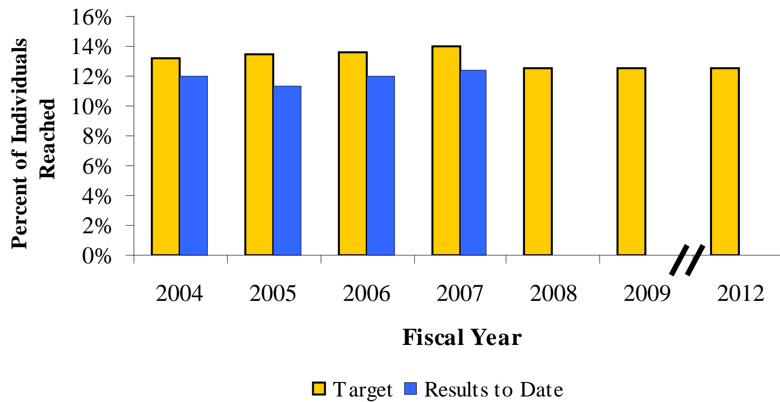
The Office on Disability (OD) represents HHS by chairing the New Freedom Initiative Emergency Response Health Subcommittee as part of the Department of Homeland Security (DHS) Interagency Coordinating Council (ICC) Workgroup to ensure emergency preparedness plans and responses at the Federal, State, Tribal, and community levels address the health and human services needs of persons with disabilities. Through collaboration with the Office of the Assistant Secretary for Preparedness and Response, OD developed an Emergency Responder Toolkit and the Shelter Intake Assessment Tool to assist States and territories in managing persons with disabilities in the event of an emergency.



Performance: An initial analysis performed by OD documented six States in FY 2006 that had emergency plans which include persons with disabilities. The FY 2007 target of 20 was not attainable due to a delay in developing and implementing the Emergency Responder Toolkit. In FY 2008, the Toolkit was completed, placed on the OD website and every State was notified that the Toolkit was ready for use. The FY 2008 target of 30 States was met. It is expected that in FY 2009 at least 40 states will have adopted the toolkit. An analysis of the number of States using the toolkit will be completed in March 2009. By FY 2012 this toolkit will be implemented in all 55 States and territories. In FY 2007 the National Red Cross used the OD Shelter Intake Assessment Tool, through a Memorandum of Understanding after Hurricane Katrina and during the 2007 California wild fires. Analysis of the Assessment Tool is an ongoing process to determine the rate, ease of use and needed enhancements.

Data Source: The Annual Assessment Report of State Emergency Management Plans and Department of Homeland Security, Administration for Children and Families, Federal Emergency Management Agency, and Indian Health Services personnel. This measure has a data lag of one year.

Measure: Increase the percentage of individuals with developmental disabilities reached by State Councils on Developmental Disabilities who are independent, self-sufficient, and integrated into the community.



The State Councils on Developmental Disabilities program at the Administration for Children and Families (ACF) assists each State in promoting the development of a comprehensive, statewide, consumer and family-centered system that provides a coordinated array of culturally-competent services and other assistance for individuals with developmental disabilities.

Performance: State Councils on Developmental Disabilities review and analyze the quantity and quality of services provided at the State and local level to influence their effectiveness for individuals with developmental disabilities. The Administration on Developmental Disabilities (ADD) at the Administration for Children and Families administers this activity in partnership with the Councils. In FY 2004, the program missed its target of 13.20 percent, reporting an actual of 12.06 percent of all individuals with developmental disabilities having been reached by the Councils. In FY 2005, the Councils reached and benefited 11.27 percent of individuals with developmental disabilities, missing the target of 13.64 percent. While there was a decline in apparent performance between FY 2004 and FY 2005, a major component of this apparent drop was an increased focus on data quality. ADD staff had worked with grantees on a State-by-State basis to make corrections, and to provide technical assistance to ensure consistency across Councils in data collection, analysis and interpretation. In working with the States, ADD was obligated to remove or reduce the reported level of some of the data values, which reduced the apparent level of performance nation-wide.

In FY 2006, ADD (in partnership with the Councils) developed and published national guidelines for data definitions, and provided training to Councils on their application creating greater uniformity of reporting. In FY 2007, the Councils improved over the previous two years' performance to 12.46 percent, but missed the target of approximately 14 percent. By FY 2009, the program expects to increase the percentage by at least 0.10 percent each year over the previous year's result. By FY 2012, the program expects to achieve the long-term target of 12.52 percent.

A primary challenge for the Councils is improving measure standardization and quality. The efficiency and effectiveness of Council projects, activities and strategies should improve through an increased emphasis on training and technical assistance on integration of strategic planning, reporting, evaluation, and performance measurement.

Data Source: The data for this measure is obtained through Program Performance Reports (PPRs) of State Councils. Outcome data are reported in annual PPRs, submitted in January of the following fiscal year through the On-Line Data Collection System. Verification and validation of data occur through ongoing review and analysis of annual electronic reports and technical assistance site visits.

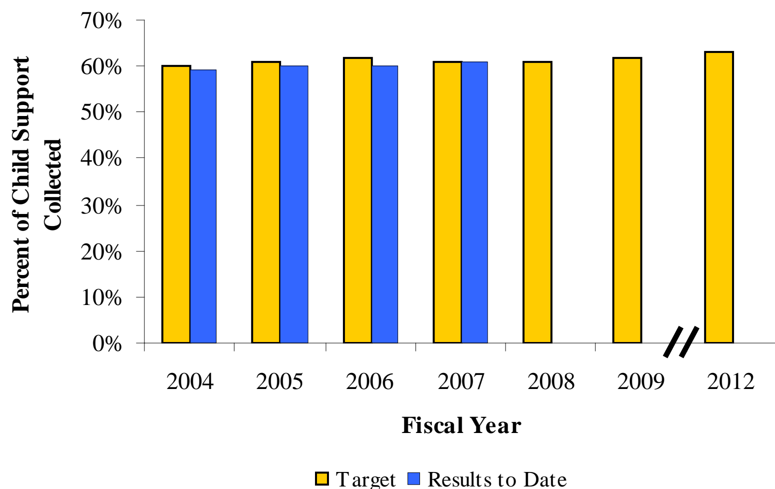
Measure: Increase the child support collection rate for current support orders.

The Child Support Enforcement (CSE) program is a joint Federal, State, Tribal, 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: 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. 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, OCSE has made great strides in expanding the reach of the program through international efforts and work with other stakeholders and partners including phenomenal growth in Tribal child support programs.

Preliminary data from FY 2007 show the total amount of child support distributed as current support was $25 billion, of which over 90 percent went directly to families. This total was nearly a four percent increase over the previous fiscal year, and it translates into a current child support collection rate of 61 percent, which met the set target for the first time in recent years. The FY 2009 target for this measure is 62 percent. Meeting this target will continue to be a challenge due to factors such as rising State budget constraints and changes mandated in the Deficit Reduction Act of 2005 that may cause program expenditures to be reduced, such as provisions decreasing Federal match. Expenditures and collections are closely related in child support; thus a reduction in expenditures could potentially result in a decreased rate of growth for child support collections.

To overcome these challenges, OCSE will work to improve performance by focusing on new and improved enforcement techniques and increased use of automation, such as the Query Interstate Cases for Kids (QUICK) application that assists interstate caseworkers in handling their cases more effectively by improving state-to-state information sharing. In addition, OCSE will disseminate best practices from a new national initiative launched in FY 2007 called PAID: Project to Avoid Increasing Delinquencies. This initiative emphasizes activities that increase current support collections and reduce arrearages, such as setting appropriate orders, employing early intervention, completing order review and modification; improving locate and enforcement; and managing existing arrears. Over 15 articles and updates on PAID best practices have been disseminated since the initiative began. In the coming year, the program will continue this important focus on activities that increase collections and prevent and/or decrease arrears. These efforts will include additional guidance documents to assist states in developing new approaches to improve program results.



Data Source: The data for this measure is obtained through the Office of Child Support Enforcement Form 157 at the Administration for Children and Families. This measure has a one-year data lag.

NOTE: The following two measures have been discontinued as a result of the elimination of the data collection system, which was terminated by the Improving Head Start Act of 2007. ACF will replace these school readiness measures with new measures that rely on alternate data systems, as described below.

Measure: Increase the percentage of Head Start programs that achieve average fall to spring gains of: A) At least 12 months in word knowledge (Peabody Picture Vocabulary Test); and B) At least four counting items.

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

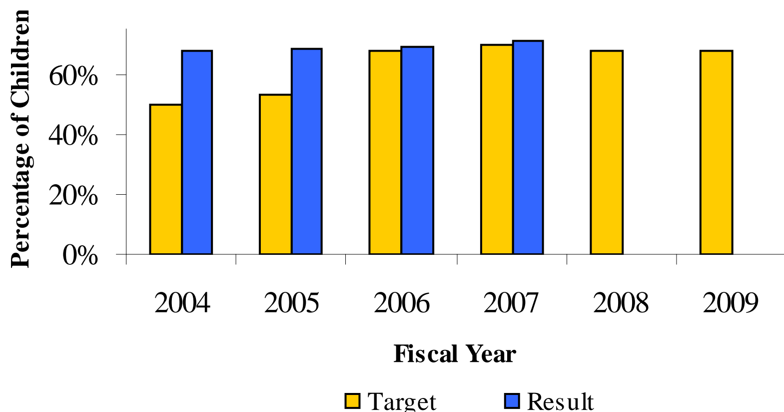
Performance: Children's word knowledge and early numeracy skills have been shown to predict improved academic performance in school and are the precursors to learning to read, write, and do arithmetic. ACF plans to develop new performance measures to track progress in these areas using data from the Family and Child Experiences Survey (FACES) cohorts. Additional performance measures on related measures of success for Head Start programs and participants rely on data from the Program Information Report (PIR) and the Office of Head Start (OHS) monitoring reviews. For example, ACF will continue to report on the number of teachers with degrees related to early childhood education. In FY 2007, over 74 percent of Head Start teachers had an AA degree or higher, surpassing the FY 2007 target of 71 percent, and significantly improving over the FY 2002 result of 47 percent.

Because of the Improving Head Start Act of 2007, which reauthorized the Head Start program, the National Reporting System (NRS) was terminated. Head Start will only report data for these performance measures through FY 2007. Data for FY 2008 and later will not be collected or reported.

In conjunction with planning for the 2009 Family and Child Experiences Survey (FACES) cohort, experts will be consulted on the best options for replacement performance measures using FACES data.

Strategic Objective 3.2: Protect the safety and foster the well-being of children and youth.

Measure: Increase the percentage of children receiving Children's Mental Health Services who have no interaction with law enforcement in the 6 months after they begin receiving services.



The Children's Mental Health Services program within the Substance Abuse and Mental Health Services Administration (SAMHSA) makes competitive grants to State and local governments to support community mental health services for children with serious emotional disturbance. Children receiving services through these grants experience improved behavioral outcomes, better school performance, and fewer disciplinary and law enforcement encounters.

Performance: The proportion of children with no interaction with law enforcement increased from 67.6 percent in FY 2004 to 71 percent in FY 2007, an indication of improved behavioral outcomes among program participants. Performance results for this measure are affected by the characteristics of grantees and the individual children served in a given year. In FY 2008, 71.7 percent of children had no law enforcement contacts at six month follow-up, exceeding the target of 69 percent. The FY 2009 performance target is for 69 percent of participants to have no law enforcement contacts at six months. This target is lower than the FY 2008 target because many recent grant awardees focus on serving youth within the juvenile justice system, a population for which contacts with law enforcement are more common.

In pursuit of continued performance improvements, SAMHSA provides new grantees with "start up" technical assistance specifically designed to support grantee attainment of performance objectives; conducts site visits to review and give feedback to grantees about their performance; hosts grantee meetings focusing on specific themes related to achieving performance objectives; develops and distributes printed materials related to performance objectives; and connects grantees with specialists who have pertinent expertise.

Data Source: The data for this measure comes from the SAMHSA Delinquency Survey.

Measure: Increase the percentage of refugees entering employment through refugee employment services funded by ACF.

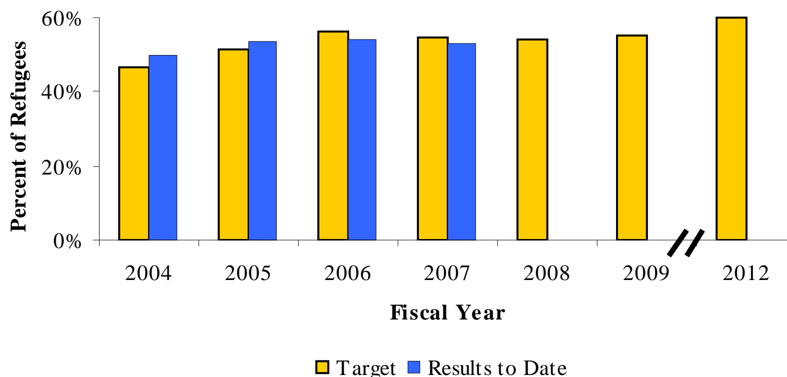
The Office of Refugee Resettlement (ORR) with the Administration for Children and Families (ACF) helps refugees and other eligible populations become employed and self-sufficient as quickly as possible. ORR funds States and non-profit organizations to provide services to refugee populations.

Performance: The percentage of refugees entering employment through ORR-funded services increased from 50 percent in FY 2004 to 54 percent in FY 2006, in part due to increased emphasis on employability services. States' and non-profits' annual targets include a three to five percent increase in the rate of refugees entering employment. ORR uses several strategies and incentives to challenge grantees to achieve their targets, including publishing outcomes in the Annual Report to Congress, presenting certificates of commendation to improved States at the annual National Consultation, and providing technical assistance and monitoring to grantees.

In FY 2007, 36,805 refugees (53 percent) entered employment through refugee employment services funded by ACF, narrowly missing the target of 54.5 percent. One of the key factors determining refugee employability is their English proficiency. Many of the activities funded by ORR focus on providing English Language Training in conjunction with specialized job training, on-the-job training, and short-term skills training targeted to local job markets. ORR-funded programs also provide supportive services such as transportation, interpretation, and child care services. These activities are designed to improve the program's performance by at least two percent over the previous year's result in FY 2009, and reach the long term goal of a 60 percent employment entry rate by FY 2014.

Due to the changing demographics of the refugee population, ORR faces continuing challenges in meeting employment targets. Recent arriving populations are ethnically diverse and in need of intensive services. For example, the U.S. State Department has indicated that, as in FY 2008, Bhutanese, Burundian, and Burmese populations will be heavily represented among arrivals in FY 2009. These groups face specific challenges to self-sufficiency. They have lived in refugee camps for extended periods of time and have mostly rural backgrounds and minimal work experience, as well as limited exposure to modern amenities and English language instruction. Many will be dealing with the effects of past trauma, including sexual and domestic violence, which impede employment success and self-sufficiency. Reports from the Burmese camps in Thailand indicate that significant numbers of women in the camp have been subjected to sexual and gender-based violence, resulting in additional trauma-related barriers to employment. Additionally, over 12,000 Iraqi refugees were resettled in FY 2008, with larger numbers anticipated for FY 2009, and they are likely to have suffered trauma due to persecution. These arrivals are expected to require intensive services to become self-sufficient.

Data Source: Data, which has a one-year lag, is obtained through ACF's Performance Reports (ORR-6), and validated by periodic desk and on-site monitoring, in which refugee cases are randomly selected and reviewed. During on-site monitoring, reported outcomes are verified with both employers and refugees to ensure accuracy.



Strategic Objective 4.2: Increase basic scientific knowledge to improve human health and human development.

Measure: Develop and apply clinically one new imaging technique to enable tracking the mobility of stem cells within cardiovascular tissues.

Scientists have begun testing cell-based treatments using stem and progenitor cells from a variety of tissues in humans, but imaging modalities are needed to track cells in intact animals and, ultimately, in humans. The ultimate goal of the research is to aid the development of cell-based therapies for cardiovascular disease. For example, several of the targets for the goal focus on cell-based therapy for peripheral arterial disease (PAD), a form of cardiovascular disease in which plaque builds up inside the walls of arteries that carry blood from the heart to the head, internal organs, and limbs. The plaque buildup causes the arteries to narrow or become blocked, which can reduce or prevent blood flow. PAD most commonly affects blood flow to the legs, and can cause pain, numbness, infection and, in severe cases, tissue death leading to amputation.

Performance: The initial pre-clinical targets for stem cell imaging for the goal have been completed successfully. Since 2005, NIH intramural researchers have successfully developed an optical microscope system and compatible probes to monitor single cells in intact animals. In 2008, NIH extramural researchers formulated a biocompatible cell encapsulation agent designed to protect and track mesenchymal stem cells for administration to patients to promote cell survival and engraftment. This advance will improve cellular therapies that currently suffer from extremely low cell engraftment due to early destruction of cells. Based on recent findings, researchers have realized the critical importance of control of stem cell differentiation to the success of stem cell-based therapy. Researchers must first understand cell differentiation before they can successfully track cell mobility and will continue working on both aspects of the goal.

This is a high-risk, long term research goal. Stem cell research is still in its infancy and, as with all research, its outcomes may support proposed hypothesis or may lead to surprising new discoveries and findings that shift the research focus.

FY	Target	Actual
2005	Initiate stem cell labeling strategy.	NIH-researchers successfully developed an optical microscope system to monitor single cells in intact animals. (Met Target.)
2006	Complete optical imaging probe development.	Researchers in the NIH intramural program have developed probes that are compatible with optical microscopy techniques developed by intramural scientists. (Met Target.)
2007	Initiate validation and toxicity studies.	Due to changes in the scientific field and a new direction for this goal, this step to initiate and validate toxicology studies was not needed at this time. (Did Not Meet Target.)
	(FY08) Initiate preclinical studies on the nature of stem cell migration in adult tissue.	NIH scientists have undertaken studies of the nature of stem cell migration in adult tissues including a preclinical study in a rat model. (Met Target in 2007.)
2008	Formulate a biocompatible cell encapsulation agent designed to protect and track mesenchymal stem cells for administration to patients to promote cell survival and engraftment.	Available February 2009
2009	Demonstrate that encapsulated cells can be tracked non-invasively by X-ray computed tomography.	Available February 2010
2012	Develop one new imaging technique that is able to be clinically applied.	Available February 2013

Data Source: The data for this measure is from NIH-funded study data.

Measure: Identify at least one clinical intervention that will delay the progression or the onset of Alzheimer's disease (AD) or prevent it.

Given the aging population, Alzheimer’s disease (AD) is a steadily increasing national health problem. Interventions that could delay or prevent the onset of AD would have an enormous positive public health impact because they would greatly reduce the number of people with the disease.

Performance: NIH has made progress in a number of areas and is continuing to facilitate discovery in each of these areas: neuroimaging and other biological markers, genetics, basic research, pre-clinical and translational research, and clinical trials. Recently, NIH-supported investigators identified the novel compound MW01-2-069A, which reduced inflammation related to AD pathology; behavioral deficits; and dysfunction at the synapse (a tiny gap between brain cells - across which either chemical or electrical signals pass) in a mouse model of AD.

This is a high risk, long term research outcome that is challenging to predict with a high degree of accuracy. The outcomes may encompass the proposed hypothesis, but unplanned results such as serendipitous discoveries and findings that narrow the avenue of the research focus (elimination discoveries) can be just as significant.

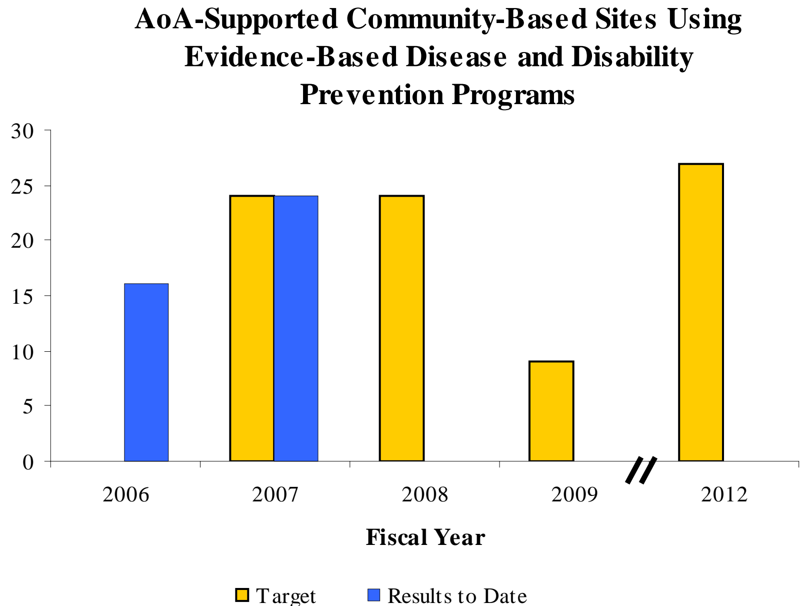
FY	Target	Actual
2004	Identify and implement effective strategies to facilitate drug discovery and development for AD treatment and prevention in collaboration with relevant organizations, as well as through stimulation of relevant research through Program Announcements and/or other mechanisms.	NIH continued a preclinical toxicology program and expanded a program for pre-clinical drug discovery and development. (Met Target.)
2005	Launch the Alzheimer's Disease Neuroimaging Initiative to evaluate neuroimaging modalities and techniques and other biomarkers to be used in early diagnosis, follow the progression of mild cognitive impairment (MCI) and AD, and use as potential surrogate markers for drug development and clinical trials.	NIH launched the Alzheimer's Disease Neuroimaging Initiative in late 2004. (Met Target.)
2006	Identify around 1,000 new late-onset AD families to allow geneticists to locate additional late onset risk factor genes for AD that may lead to new targets for drug treatment, and provide a well-characterized population for more efficient clinical trials.	Nearly 1,000 new late-onset AD families have been identified and recruited to the AD Genetics Initiative. (Met Target.)
2007	Identify and characterize molecular events that may prove to be targets for treating or preventing Alzheimer's disease through initiatives and projects focused on mechanistic and basic studies.	NIH-supported research has helped to identify and characterize two particularly promising target molecules for AD treatment and development: beta-amyloid production and p38 alpha MAPK. (Met Target.)
2008	For at least one promising drug candidate for the treatment of AD, complete at least one of the four preclinical steps necessary for regulatory approval: chemical optimization; proof of efficacy in an animal model relevant to the disease; pharmacokinetic profiling; and/or early toxicology screening.	NIH-supported investigators identified the compound MW01-2-069A, which reduced brain inflammation and behavioral deficits in a mouse model of AD. (Met Target.)
2009	Start at least one pilot clinical trial on promising interventions based on results of previous trials and new leads for drug discovery.	Available February 2010

Data Source: The data for this measure is from NIH study data.

Strategic Objective 4.4: Communicate and transfer research results into clinical, public health, and human service practice.

Measure: Increase the number of AoA-supported community-based sites that use evidence-based disease and disability prevention programs.

The Evidence-Based Disease and Disability Prevention (EBDP) Program, through the Administration on Aging (AoA), empowers older people to take control of their own health through lifestyle changes that have proven effective in reducing the risk of disease and disability among the elderly and enabling those with chronic conditions to better manage their own care. Currently, the primary program components are: Chronic Disease Self-Care; Physical Activity; Falls Prevention; Nutrition and Diet; and Depression.



Performance**:** Between FY 2003 and FY 2006, AoA funded 12 community-level sites to demonstrate and evaluate the capacity of the Aging Services Network to successfully implement EBDP programs validated by HHS-sponsored research. The evaluation results of the EBDP program confirmed the capability of the Aging Services Network to effectively deliver EBDP community programs to diverse elderly populations.

In FY 2006, AoA provided funds to 16 States to build capacity to replicate, manage, and provide program operating funds for the EBDP program through the Aging Services Network. In FY 2007, an additional eight States were awarded grants to implement similar programs. Presently, 24 AoA-supported States are using EBDP programs.

In FY 2009, AoA will target up to five States as part of a broader demonstration project. The Administration on Aging will evaluate the project to determine whether savings in Medicaid and Medicare can be achieved through the use of low-cost home and community-based alternatives, including evidence-based prevention activities. Because these efforts will be targeted at three to five demonstration States, fewer sites will be funded in FY 2009.

AoA faces several challenges in meeting the long-term target of 27 sites by FY 2012. For example, expanding these programs to additional sites requires substantial training and program development to establish and maintain fidelity to the original program design and to assure health benefits for older adult clients. AoA has helped the current sites overcome these challenges by requiring the programs to partner with State and local health agencies and other organizations. States, public and private agencies, and foundations at every level have been receptive to EBDP programs. Because many older adults are receptive to an opportunity to learn and make behavioral changes that will help them manage their chronic diseases, the programs are gaining momentum.

Data Source: The data for this measure is from AoA's Evidence-Based Disease Prevention discretionary grant semiannual reports.

Measure: Reduce the disparity between African American and White infants in back sleeping by 50% to reduce the risk of Sudden Infant Death Syndrome (SIDS).

The NIH, in collaboration with campaign sponsors, is leading the national Back to Sleep public health education campaign, which promotes placing babies on their backs to sleep to reduce the risk of SIDS.

Performance: The NIH has successfully implemented comprehensive strategies to promote safe sleeping practices in African American communities. First, the NIH launched a multi-year project to disseminate the American Academy of Pediatrics safe sleep guidelines in Mississippi. Second, a continuing education curriculum was developed for nurses on the safe sleep guidelines and effective ways to convey the risk reduction message. This curriculum is being implemented at regional and national conferences. In 2008, NIH distributed over 47,000 special "Back to Sleep" campaign materials targeting African American communities in collaboration with the Arkansas Department of Health.

A challenge to this goal is the lack of a quality national data source to measure the impact of the SIDS outreach campaign. The national data source uses convenience sampling, which is not representative of the population as a whole and may not reflect the full achievements of the program. To address this challenge, the NIH recently initiated a study to examine trends in infant care practices, and environmental and cultural influences on the diffusion of the public health recommendations in a nationally representative sample of minority and non-minority mothers.

FY	Target	Actual
2004	Conduct 250 interviews among the approximately 1,500 participants who attended the three summit meetings held in FY 2003 to determine that each summit resulted in a minimum of 50 outreach activities.	Interviews were held with participants from each summit and 150 outreach activities resulted from each of the summits. (Met Target.)
2005	Continue to extend 'Back to Sleep' campaign messages to African American populations through community-based collaborations/partnerships by involving a minimum of six national organizations in SIDS training and educational activities.	NIH extended the 'Back to Sleep' campaign messages to African American populations through community-based collaborations with eight national organizations in SIDS training and educational activities. (Met Target.)
2006	Promote a continuing education module with at least six national nursing organizations serving African American communities to extend the Back to Sleep campaign messages.	The Nurses Continuing Education Program was presented at eight national and four regional nurses conferences. Approximately 5,250 nurses participated in the training. (Met Target.)
2007	Extend the continuing education module for nurses in appropriate community-based clinical settings in African American communities in the Mississippi Delta region.	NIH extended the continuing education module to approximately 50 nurses in the Mississippi Delta Region. (Met Target.)
2008	Distribute approximately 43,000 special "Back to Sleep" campaign materials targeting African American communities in collaboration with the Arkansas Department of Health.	Distributed over 47,000 special "Back to Sleep" campaign materials. (Met Target.)
2009	Conduct a continuing education program for approximately 500 pharmacists in the DC metro area.	Available February 2010

Data Source: The data for this measure is from NIH study data.