Section II - Program Performance by HHS Strategic Goal

Program Performance

The Department of Health and Human Services (HHS) is one of the largest federal agencies, the nation's largest health insurer; and the largest grant-making agency in the Federal government. The Department protects and promotes the health and well-being of all Americans and provides world leadership in biomedical and public health sciences. HHS has established eight strategic goals for accomplishing its mission to protect and improve the health and well-being of the American public. These goals, which provide a focus for HHS investments over the next five years, are the framework for the performance measures which track how we are doing.

Sound information is essential to HHS' mission of enhancing the health and well-being of Americans. For every HHS performance measure - whether providing for effective health and human services or fostering sustained advances in medicine and health - reliable and readily available information is necessary for planning, decision making, and measuring results. The Department plays an essential role in producing data for decision-making for health and human services programs, both as a direct producer and as a partner in data collection with the states, grantees, and other governmental agencies.

Programs and operating components rely upon data for program management, policy decision making, and intervention development. The Government Performance and Results Act (GPRA) reinforced the perspective of data for decision making and encouraged staff throughout HHS to accurately reflect and refine our data systems. As a result, our programs work extensively with its partners - state, local and tribal governments, grantees, and Medicare contractors - in program implementation and data collection to identify enhancements to these systems that would improve the timeliness, completeness, and accuracy of our data and enable us to move to more sophisticated measures of performance.

Key challenges include:

- Data systems need to produce data on a more timely basis and with a frequency relevant to the periods over which performance is being measured;

- As the health system continues to change, current data collections may not continue to produce needed data;

- Many of the interventions for complex chronic diseases or social problems require years of focused efforts to realize significant progress;

- Many HHS programs are implemented at the state and local level, and obtaining reliable, systematic data at these levels is crucial in order to monitor program implementation, performance, and outcomes;

- Data systems need to produce information with sufficient quality and precision to detect what may be relatively small changes in key performance goals; and

- Major changes in complex data collection systems take time.

Efforts are under way in HHS at the program office, operating component, and department levels to enhance the data that is available to our program offices and partners for planning, decision-making, and measuring results. These efforts include developing new data collections, enhancing current data collections, eliminating data collections that are no longer relevant, combining reporting where possible, and building capacity to collect data at the state and local level.

The Department manages over 300 programs. The programs included in this report are intended to fairly highlight the many ways that HHS is leading America to better health, safety and well-being. To accomplish that, we selected programs that reflect each of our eight strategic goals, and represent the many agencies that make up the Department. For more detailed information, see the most recent Department Annual Performance Report located at www.hhs.gov/budget/docgpra.htm.

The data contained in the following tables reflect information that were available at or immediately prior to the information cut-off date of September 30, 2002. In some cases more recent information may be available in agency documents that were updated following that compilation. Data was obtained from the same data systems, regardless of date.

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

HHS has taken significant steps to reduce health threats through prevention, promoting healthy behaviors, and building partnerships with states, communities, and health professionals. We have encouraged the use of early detection and screening services; provided support to states, tribes, and communities to help them expand and improve substance abuse prevention; and disseminated information to patients and healthcare providers about the importance of vaccinations.

Several illustrative programs at HHS, detailed below, have annual performance measures that demonstrate in concrete terms how the Department has reduced threats to the health and well-being of Americans.

Chronic Disease Prevention & Health Promotion
Centers for Disease Control and Prevention (CDC)

The Program

Chronic diseases - such as cancer, heart disease and diabetes - are the leading causes of death and disability in the United States. These diseases account for seven of every ten deaths and affect the quality of life of 90 million Americans. Although chronic diseases are among the most common and costly health problems, they are also among the most preventable. Adopting healthy behaviors such as eating nutritious foods, being physically active, and avoiding tobacco use can prevent or control the devastating effects of these diseases.

CDC's National Center for Chronic Disease Prevention and Health Promotion is at the forefront of the Nation's efforts to detect, prevent, and control chronic diseases. The center conducts studies to better understand the causes of these diseases, support programs to promote healthy behaviors, and monitors the health of the nation through surveys. Instrumental to the success of these efforts are partnerships with state health and education agencies, voluntary associations, private organizations, and other federal agencies. Together, the Center and its partners work to create a healthier nation.

CDC's Chronic Disease Prevention and Health Promotion program is made up of a variety of efforts, including Breast and Cervical Cancer, Tobacco Use Prevention, Community-Based Prevention Research, Heart Disease and Stroke, Arthritis, the National Program of Cancer Registries, HIV Prevention Among School-Aged Youth, and Behavioral Risk Surveillance. A few of these programs are detailed below.

Results and Explanation of Performance

Breast and Cervical Cancer: The National Breast and Cervical Cancer Early Detection Program (NBCCEDP) was created by Congress with the passage of the Breast and Cervical Cancer Prevention Mortality Act of 1990 to increase access to and use of breast and cervical cancer screening services for low-income, uninsured, or under-insured women. One goal of this program is to diagnose at least 70 percent of women aged 40 and older in the NBCCEDP who have breast cancer (excluding breast cancers identified on an initial screen).

Performance Measure: Excluding breast cancers diagnosed on an initial screen in the NBCCEDP, diagnose at least 70 percent of women aged 40 and older at the localized stage.*		
	Target	Actual
FY 2002	70%	04/2003
FY 2001	69%	64%
FY 2000	72%	66%
FY 1999	71%	70%

(Source: CDC's NBCCEDP)
* First mammogram provided through CDC's NBCCEDP

Although the program has diagnosed almost 12,000 breast cancers, meeting the ambitious goal of approximately 70 percent detection has been challenging. Difficulties in meeting the goal have been compounded by potential data problems. NBCCEDP discovered that some programs in a small number of states were not consistently reporting data. More involved analysis is being done at CDC to better understand the data issues, including a study that will compare NBCCEDP data with the national Cancer Registry program data. Upon completion of the studies, developmental performance measures will be introduced.

Heart Disease: Heart disease and stroke is the nation's number one killer of men and women across all ages and ethnic groups. One of CDC's performance measures has been to increase the number of states with five of the seven core heart disease and stroke prevention capacities. These capacities are: 1) partnership development; 2) scientific capacity; 3) policy and environmental strategies; 4) state cardiovascular health plan; 5) training and technical assistance; 6) population based strategies; and 7) strategies for priority populations.

Performance Measure: Increase the number of states with five of the seven core heart disease and stroke prevention capacities.		
	Target	Actual
FY 2002	20 states	06/2003
FY 2001	15 states	18 states
FY 2000	11 states	15 states
FY 1999	8 states	11 states

(Source: CDC FY 2002 Annual Performance Report)

Leveraging the success it has had, CDC is shifting its focus from establishing prevention capacities in states to measuring the outcomes of these programs. These outcomes will include decreasing heart disease and stroke deaths that occur before a patient is transported to the hospital, and reducing the prevalence of uncontrolled high blood pressure.

Diabetes: Over 17 million Americans suffer from diabetes and the number of new cases is increasing steadily. CDC's National Diabetes Program conducted health promotion and disease prevention activities to improve the quality of care that health systems provide to people with diabetes. The program activities promoted and supported preventive health care services proven to be effective in reducing the onset and progression of diabetes-specific complications.

One of CDC's diabetes performance measures has been increasing the percentage of diabetes control programs that adopt, promote, and implement guidelines for improving the quality of care for persons with diabetes. By the end of FY 2001, 100 percent of the State Diabetes Control programs had adopted, promoted, and implemented guidelines for improving the quality of care for persons with diabetes.

Over 17 million Americans suffer from diabetes and the number of new cases is increasing steadily.

Performance Measure: Increase the percentage of diabetes control programs that adopt, promote, and implement guidelines for improving the quality of care for persons with diabetes.		
	Target	Actual
FY 2002	100%	12/2002
FY 2001	100%	100%
FY 2000	100%	85%
FY 1999	New	70%

(Source: state quarterly reports; Behavioral Risk Factor Surveillance System)

CDC continues to work with states to sustain this effort, providing consultation and technical assistance. In the states that have adopted and implemented guidelines to improve the quality of care for persons with diabetes, CDC aims to expand and improve this effort.

Disease Prevention and Health Promotion
Office of Public Health and Science (OPHS)

The Program

Within the OPHS, several programs provide leadership within the Department and indeed nationally in promoting health and preventing disease. Specifically, OPHS' Office of Disease Prevention and Health Promotion (ODPHP) leads cross-cutting national initiatives within and/or on behalf of the Department. *Healthy People 2010*, the third comprehensive decade-long prevention initiative led by ODPHP, reflects national priorities which are in turn led by HHS agencies. It shapes state and local health planning and the agendas of academic research, professional, and voluntary organizations. The *Healthy People 2010* Leading Health Indicators, a nationally accepted set of ten health priorities, provide a user-friendly way to communicate prevention to the public and mobilize all sectors around major public health issues, including overweight, obesity, physical activity, tobacco use, substance abuse, immunizations, and injury and violence.

Results and Explanation of Performance

Cigarette Smoking: Cigarette smoking is the single most preventable cause of disease and death in the United States. The goals of comprehensive tobacco prevention and reduction efforts include preventing young people from starting to use tobacco. In 1999, 35 percent of adolescents in grades 9 through 12 were cigarette smokers. Significant progress was achieved in FY 2000 and maintained in FY 2001, when the percentage of youth smokers was only 28 percent.

Performance Measure: Past month use of cigarettes by youth in grades 9 - 12.		
	Target	Actual
FY 2002	33.9%	10/2004
FY 2001	35.9%	28%
FY 2000	36.3%	28%
FY 1999	36.4%	35%

(Sources: 1999 and 2001, Youth Risk Behavior Survey, CDC; 2000 and 2002, National Youth Tobacco Survey, CDC)

Promotion of the Leading Health Indicators by OPHS helped contribute to meeting this performance measure by focusing attention on tobacco use as a national challenge. Effective prevention approaches for reducing tobacco use among adolescents include school-based prevention programs as an integral part of community-wide strategies that address the overall social context of tobacco use. School-based tobacco prevention programs identify the social influences that promote tobacco use among youth and teach skills to resist these influences. Such programs, led by the CDC, have demonstrated consistent and significant reductions or delays in adolescent smoking.

Physical Activity: Regular physical activity is associated with lower death rates for adults of any age, even when individuals engage in only moderate levels of physical activity. Regular physical activity decreases the risk of death from heart disease, lowers the risk of developing diabetes, prevents and reduces high blood pressure, and is associated with a decreased risk of colon cancer. The goal is to increase the proportion of adults who develop regular physical activity patterns, preferably daily, to promote health and prevent disease. Because of the importance of physical activity, targets have been raised for this decade. The Physical Activity Leading Health Indicator is an important tool for mobilizing action to achieve them.

Performance Measure: Percent of people aged 18 and older who engage in moderate physical activity for at least 30 minutes per day, five or more times a week.		
	Target	Actual
FY 2002	35.6%	12/2004
FY 2001	33.8%	32%*
FY 2000	30%	32%
FY 1999	29%	30%

*Preliminary data
(Source: National Health Interview Survey, CDC)

More broadly, ODPHP, together with the other offices within OPHS, has been engaged in overarching efforts to promote the health of the nation. A number of strategic *Healthy People 2010* partnerships have been forged to catalyze health improvements. These formal partnerships

were developed with federal, national, grassroots, and community organizations. Each partnership fundamentally changes or enhances the disease prevention or health promotion activities of the partner organization and its members. OPHS brings carefully selected information about disease prevention and health promotion to the public via the following Web site http://www.healthfinder.gov. The site provides access to a wealth of general health information as well as providing targeted information for special populations such as seniors, adolescents, Hispanics, caregivers, and community leaders. In FY 2002, new sections for American Indian and Alaska Natives were added.

HIV/AIDS

Centers for Disease Control and Prevention (CDC)

The Program

CDC has been involved in the international fight against HIV/AIDS from the earliest days of the epidemic, and remains a global leader in HIV/AIDS prevention and control. UNAIDS, the joint program run by the United Nations and World Bank, estimates that there are 42 million adults and children living with HIV/AIDS and nearly 22 million have died. The most severely affected countries are currently sub-Saharan Africa; 70 percent of those living with HIV/AIDS reside in this region. But the National Intelligence Council recently predicted that by 2010 there will be between 50 million and 75 million cases of HIV in India, China, Ethiopia, Nigeria, and Russia. CDC worked with HRSA, NIH, the U.S. Agency for International Development (USAID), the Department of State, and other agencies and organizations to help other countries address the devastating impact of HIV/AIDS. CDC worked with host nations and other key partners to assess the needs of each country and design a customized program of assistance that fits within the host nation's strategic plan.

Results and Explanation of Performance

CDC strengthened voluntary HIV/AIDS counseling and testing programs in 18 countries. These programs provided technical assistance to ensure the quality and accuracy of HIV testing, strengthened laboratory diagnostic capabilities, identified methods to target groups at high risk, and enhanced links between this program and health and social services. In 2001, CDC staff in Botswana, Ivory Coast, Ethiopia, Kenya, Malawi, Mozambique, South Africa, Uganda and Vietnam have supported, co-sponsored, or attended 95 meetings in Africa relating to the development of national, regional, district, or local planning and policy guidelines for voluntary counseling and testing. Over 144,000 individuals were tested at voluntary counseling and testing sites supported by CDC funds in Botswana, Ivory Coast, Kenya, Malawi and Uganda.

Performance Measure: Initiate, expand, or strengthen HIV/AIDS voluntary counseling and testing globally. (Measure: number of countries/regions)		
	Target	Actual
FY 2002	25	09/2003
FY 2001	19	18
FY 2000	12	12
FY 1999	New	-

(Source: CDC FY 2002 Performance Report)

Tuberculosis Prevention

Centers for Disease Control and Prevention (CDC)

The Program

Tuberculosis (TB) was once the leading cause of death in the United States. The Public Health Service Act Section 317E charges CDC with the responsibility of administering a program to prevent, control and eliminate TB. All 50 states and the District of Columbia continue to report TB cases every year, and each new case has the potential to spread if not promptly diagnosed and treated.

Many people think that TB is a disease of the past. One reason for this is that the U.S. is currently seeing a decline in TB and new cases are at an all-time low. Yet, TB poses a considerable challenge. There were nearly 16,000 cases of TB in 2001 and each new case had the potential to spread if not promptly recognized and treated. Compounding this threat are the increasing proportion of TB cases among persons born outside of the U.S., and drug-resistant strains of TB. If a person with TB does not complete their full course of treatment, they can develop and spread strains of TB that are resistant to available drugs.

The spread of TB can be effectively reduced by identifying those afflicted with the disease and assisting them in completing treatment within 12 months. Patients need to take several drugs to combat TB, and after taking medicine for a few weeks they begin to feel better. But TB bacteria die very slowly and it takes at least six months of continuous treatment for the medicine to kill all the TB bacteria. This makes a prompt and complete course of treatment a high priority. CDC aims to achieve an 88 percent completion rate by designing improved training aids for health departments, and employing outreach workers from diverse language, cultural and ethnic groups that have high TB incidence.

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Performance Measure: Increase the percentage of TB patients who complete a course of curative TB treatment within 12 months of initiation (some patients require more than 12 months).		
	Target	Actual
FY 2002	88%	mid-2005
FY 2001	88%	mid-2004
FY 2000	85%	mid-2003
FY 1999	85%	79.9%

(Source: TB Surveillance System)

To accomplish this goal, CDC supports outreach workers hired from language, cultural, and ethnic groups with high TB incidence. Outreach workers helped TB patients complete treatment through Directly Observed Therapy, incentives, and other adherence strategies. CDC and CDC-funded Model TB Centers also designed and implemented training and educational aids for health department and healthcare provider staff to improve the skills needed to help achieve this objective.

Immunization
Centers for Disease Control and Prevention (CDC)

The Program

CDC protects the health of American children and adults from disability and death associated with vaccine-preventable diseases by developing and implementing immunization programs and monitoring vaccine use. Vaccines are responsible for controlling many infectious diseases, including diphtheria, measles, mumps, and pertussis.

Vaccine interventions have reduced cases of all vaccine-preventable diseases by more than 97 percent from peak levels before vaccines were available, making them among the greatest public health achievements of the 20th century. Vaccines are also cost-effective. CDC estimates that every dollar spent on diphtheria-tetanus-acellular pertussis vaccine saves $27 in direct and indirect costs (indirect savings includes work loss, death, and disability) that would be spent treating otherwise preventable disease.

Results and Explanation of Performance

CDC's success in reducing the number of indigenous cases of vaccine-preventable diseases is clear. Indigenous cases of tetanus were most recently reported to be under 30; rubella under 20; diphtheria and congenital rubella in the single digits; and polio currently at zero. Following an extensive review of epidemiology, imported cases, population immunity, and the quality of surveillance, an expert panel concluded that measles is no longer an epidemic in the U.S.

Performance Measure: The number of indigenous cases of measles in children under 5 years of age will remain at or be reduced to zero by 2010.		
	Target	Actual
FY 2002	60	09/2003
FY 2001	60	26*
FY 2000	0	63
FY 1999	0	66

(Source: National Notifiable Disease Surveillance System, and others)
* Provisional data

Although substantial progress has been made to reduce or eliminate these diseases, total eradication of some of them is unlikely to occur. Where vaccination does not significantly impact transmission or where transmission occurs in a population that cannot be vaccinated, such as pertussis, significant cases will continue to occur. Where protection from vaccination occurs in the U.S. but not globally, diseases like rubella will continue to be introduced by travelers and immigrants.

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

HHS has developed a number of initiatives and programs and devoted numerous resources, increasing bioterrorism spending by more than thirteen-fold between 2001 and 2003, to protect Americans from bioterrorist attacks and other public health care challenges. The events of September 11, 2001, and subsequent anthrax attacks have reinforced HHS' role in protecting people in America from attacks on our food and health by enhancing emergency preparedness.

The following programs illustrate HHS' broad commitment to strengthening the public health infrastructure. CDC has an integral role in strengthening local public health infrastructure to effectively respond to emergencies. The Office of the Public Health Preparedness in the Office of the Assistant Secretary for Public Health Emergency Preparedness (OASPHEP) is also enhancing local preparedness and coordinates the deployment of medical personnel, equipment, and medical products in the event of a major disaster. The Food and Drug Administration (FDA) is also playing a major role in its postmarket activities by inspecting high risk domestic food manufacturers and enhancing food import inspections to protect our nation's food supply and prevent food borne illness.

Bioterrorism Programs

Centers for Disease Control and Prevention (CDC)

The Program

A future terrorist threat to the U.S. may involve biological, chemical, or radiological weapons.

Local emergency medical, fire, police, and public health agencies stand on the front lines of any response. How well the U.S. responds, therefore, depends on that local preparedness and the readiness of state and federal government to augment local efforts.

CDC is key to that federal augmentation. CDC is responsible for leading national efforts to detect, respond to, and prevent illness and injury that result from the deliberate release of biological agents. Additionally, CDC plays a key role in dealing with health-related issues arising from the release of chemical or radiological agents, as well as mass trauma that could result from the use of weapons of mass destruction.

Results and Explanation of Performance

Performance Measure: Maintain a national pharmaceutical stockpile for deployment in response to terrorist use of biological or chemical agents against the U.S. civilian population.		
	Target	Actual
FY 2002	Maintain a pharmaceutical stockpile as required by FY 2002 HHS Bioterrorism Strategic Plan.	Exceeded
FY 2001	Maintain a pharmaceutical stockpile as required by draft HHS Bioterrorism Strategic Plan.	Achieved
FY 2000	Maintain a pharmaceutical stockpile as required by draft HHS Bioterrorism Strategic Plan.	Exceeded
FY 1999	Create a stockpile, including the ability to protect 1 million - 4 million against anthrax.	Achieved

(Source: CDC Performance Plan, Sept. 2002)

Congress gave CDC the mission to manage and oversee the National Pharmaceutical Stockpile (NPS) in January 1999. There are two components of the NPS program. One component of this program was the ability to deliver drugs and medical components to a site in the U.S. within twelve hours of a federal order to deploy. The delivery of drugs and components is called a "push package," and there are twelve such packages located across the U.S. for security purposes and as insurance against multiple attacks. A second component of the program was establishment of a vendor-managed inventory (VMI). This is a stockpile of drugs and material made and stored for CDC. During FY 2001 VMI contracts were awarded and the material was readied for deployment. The detailed requirements for these components are contained in the HHS Bioterrorism Strategic Plan.

It is noteworthy that the first time the NPS was deployed was in response to the September 11, 2001 terrorist attacks in New York and Washington, DC. The "push package" of drugs and material arrived in New York within seven hours of approved deployment. A second "push package" arrived in Washington following the terrorist attack on the Pentagon. Since then, CDC has used the NPS to deliver 3.75 million tablets of antibiotics for postexposure prophylaxis of postal workers, mail handlers, and other citizens after the first cases of anthrax were identified in Florida and North Carolina.

Public Health and Medical Preparedness Programs
Office of the Assistant Secretary for Public Health Emergency Preparedness (OASPHEP)

The Program

OASPHEP was established to direct the Department's efforts in preparing for, protecting against, responding to, and recovering from all acts of bioterrorism and other public health emergencies that affect the civilian population. OASPHEP serves as the focal point within HHS for these activities, and directs and coordinates the implementation of a comprehensive HHS strategy. A major component of OASPHEP is the Office of Emergency Response (OER), transferred from the Office of Public Health and Science (OPHS), and formerly named the Office of Emergency Preparedness. OER is the primary OASPHEP component for emergency response operations. In carrying out this responsibility, OER utilizes the resources of the National Disaster Medical System (NDMS) which includes mobile medical response teams providing primary and specialized care, and a nation-wide hospital system with approximately 100,000 hospital beds in 2,000 hospitals.

Results and Explanation of Performance

OASPHEP coordinated the award of over $1.1 billion in public health and hospital preparedness funding (through cooperative agreements) to the 50 states. It also directed the department-wide review of 121 work plans submitted by states for both public health and hospital preparedness which was completed in an unprecedented 30-business-day period, involving 280 reviewers drawn largely from HHS agencies but also including staff from other federal departments and agencies.

In the area of medical and public health response, OASPHEP has:

- Responded to six different emergencies concurrently for the first time;

- Engaged in the longest continual activation of the NDMS in its history beginning on September 11, 2001 through the end of August 2002;

- Established and operated the Secretary's Command Center (SCC) to serve as a single point of emergency contact for HHS; the SCC has responded to over 8,000 communications and along with HHS emergency operations centers has monitored nearly 600 cases potentially related to terrorism;

- Successfully prepared for and activated NDMS resources in support of special events, including the United Nations General Assembly Meeting, the Fourth of July, the Israeli Solidarity Rally on Capitol Hill and the President's State of the Union Address;

- Planned and put in place on-site health and medical pre-positioned NDMS staff for the 2002 Olympics in Salt Lake City;

- Established the Secretary's Emergency Response Team (SERT) concept providing the Department with a centralized coordination element for all public health emergencies, whether domestic or international. Team roster includes liaison representatives from CDC, NIH, FDA, IHS, and SAMHSA; and

- Trained approximately 600 students at the Noble USPHS Training Center which serves as an advanced training center for the national and international medical response to mass casualty incidents resulting from both natural and man-made events.

Foods Program- Post-Market Activities
Food and Drug Administration (FDA)

The Program

The FDA, in close collaboration with other agencies like the CDC, U.S. Department of Agriculture, and Environmental Protection Agency, has been working to reduce the incidence of food-borne illness through regulatory action, high-risk food inspection activities as well as monitoring and reducing the amount of pesticides in foods.

The events of September 11, 2001 reinforced FDA's role in protecting our nation's food supply by focusing efforts, such as food import inspection, on foods under its statutory authority, which includes all foods apart from meat and frozen and dried eggs, which are regulated by the USDA. FDA has begun the process of hiring and training new investigators, analysts, and other personnel, as authorized by the FY 2002 Counter Terrorism Supplemental Appropriation. These personnel improve the FDA's capacity to respond to terrorist threats and attacks and augment domestic food safety and security. Many of these employees are investigators and analysts who closely monitor the highest risk imports entering the country, and have enabled FDA to increase border presence by doing more field exams, sample collection and analysis, domestic inspections, and laboratory analyses.

Results and Explanations of Performance

The performance measures below illustrate FDA's effort to reduce food-borne illness and protect the nation's food supply through such activities as inspection of high-risk food establishments and enhanced food import surveillance.

> Imported foods now constitute more than 10 percent of the U.S. food supply, and for some commodities such as fresh fruits and vegetables, 40 percent or more are imported.

Performance Measure: Inspect at least 95 percent of high-risk domestic food establishments once every year.		
	Target	Actual
FY 2002	95%	mid-FY 2003
FY 2001	90%	Approx. 80% of 6,800
FY 2000	90-100%	91% of 6,250
FY 1999	No measure	No measure

(Source: Field Data Systems)

FDA defines high-risk food establishments as those producing foods with the greatest risk for microbial contamination. These establishments could include manufacturers, packers/repackers, and warehouses processing products such as seafood; soft, semi-soft cheese; unpasteurized juices; leafy vegetables; prepared salads; and infant formula, among others. In FY 2002, the high-risk food inventory grew with the designation of additional high-risk products such as foods that contain common allergenic substances such as milk, eggs, seafood, and nuts, as well as dietary supplements that contain bovine ingredients from countries where bovine spongioform encephalopathy (BSE) has been prevalent. FDA identifies high-risk foods with the assistance of CDC's FoodNet, an active surveillance system, which tracks food-borne illness in the United States.

In FY 2001, FDA inspected nearly 80 percent of the identified 6,800 inventory. FDA fell short of its target of 90 percent because they shifted resources and efforts to mitigate the threat of BSE, also known as "Mad Cow Disease", as it continued to spread in Europe.

Performance Measure: Perform 48,000 physical exams and conduct sample analyses on products with suspect histories.		
	Target	Actual
FY 2002	-Increase food surveillance by hiring 300 new investigators -24,000 exams	mid-FY 2003
FY 2001	No measure	12,169 exams
FY 2000	No measure	No measure
FY 1999	No measure	No measure

(Source: Field Data Systems)

Imported foods now constitute more than 10 percent of the U.S. food supply, and for some commodities such as fresh fruits and vegetables, 40 percent or more are imported. In fact, FDA data show that the number of imported food entries has doubled over the past seven years. With such dramatic increase in import volume, FDA has taken a risk-based approach. In FY 2002, FDA sought to examine those products which pose a greater risk to the food supply, particularly those products which have suspect histories.

Although FY 2002 final data is not available yet, the preliminary data indicates that FDA will meet this target. FDA has made great strides in the hiring and training of new personnel. They have begun the process of hiring and training 655 new investigators, analysts, and other support personnel as authorized by the FY 2002 Counter Terrorism Supplemental Appropriation.

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

Bioterrorism is not the only threat facing our Nation. Disparities in health care within the U.S. population are of great concern to HHS. We worked to expand health care to all. Therefore, HHS sought to create new, affordable health insurance options and expand the health care safety net.

Additionally, we aimed to strengthen and improve Medicare as well as help to train an adequate supply of nurses. We also planned to expand access to health care services for populations with special needs. Over 530,000 low-income and uninsured individuals depend on the Ryan White CARE Act program for medical care and other essential support services.

Medicare

Centers for Medicare & Medicaid Services (CMS)

The Program

The CMS administers Medicare, the nation's largest health insurance program, which covers over 40 million Americans. Medicare provides health insurance to people age 65 and over, those who have permanent kidney failure, and certain people with disabilities. For almost four decades, this program has helped pay medical bills for millions of Americans, providing them with comprehensive health benefits they can count on.

The CMS' primary mission is to assure health care security for its beneficiaries. Also, CMS strives to encourage choice in the Medicare beneficiary community for medical coverage while maintaining highquality care.

Results and Explanation of Performance

Beneficiaries are Medicare's primary customers. One of CMS' primary goals is to assure satisfaction in the experiences beneficiaries have in accessing care for illnesses and injuries when needed, including their access to care of specialists. In response to the need to standardize the measurement of and monitor beneficiaries' experience and satisfaction with the care they receive through Medicare, CMS developed a series of data collection activities under the Consumer Assessment Health Plans Surveys (CAHPS). The CMS fields these surveys annually to representative samples of beneficiaries enrolled in each Medicare managed care plan as well as those enrolled in the original Medicare fee-for-service plan and provides comparable sets of specific performance measures collected in CAHPS to Quality Improvement Organizations (QIO), health plans, and beneficiaries through various means, including the National *Medicare & You* Education Program (NMEP).

Performance Measure: Improve satisfaction of Medicare beneficiaries with the health care services they receive (Managed Care).		
	Target	Actual
FY 2002	Collect/share data	Data collected; goal met
FY 2001	Develop new baselines/targets to include disenrollee data	Access to care: 90.5% beneficiaries Access to specialist: 83.7% (baseline)
FY 2000	Collect/share data to achieve 79% of plans for access to care and 75% of plans for access to specialist by CY 2003	Data collected; goal met
FY 1999	Develop target	Target developed

(Source: Medicare CAHPS)

Performance Measure: Improve satisfaction of Medicare beneficiaries with the health care services they receive (fee-for-service).		
	Target	Actual
FY 2002	Collect/share data	Data collected; goal met
FY 2001	Develop baselines/targets	Access to care: 92.8% beneficiaries Access to specialist: 82.8% (baseline)
FY 2000	Same as FY 1999	Survey fielded in FY 2001 w/baseline data available Fall 2001
FY 1999	Continue to develop measurement and reporting methodology	Development continuing with survey to be fielded in FY 2001

(Source: Medicare CAHPS)

The CMS' multi-year efforts to improve beneficiary satisfaction with the health care received apply to both managed care and fee-for-service (FFS). In an effort to capture more complete information for the managed care portion, data from a managed care disenrollee survey is combined with survey data from current managed care enrollees. Baselines and targets have been recalculated to reflect this change. In order for the increases to be statistically significant, these are long-term targets with reporting due at the end of the 5-year period.

Complications arising from pneumococcal disease and influenza kill more than 30,000 people each year in the United States – resulting in more deaths per year than for all other vaccine-preventable diseases combined. For all persons age 65 and older, the Advisory Committee on Immunization Practices (ACIP) and other leading authorities recommend lifetime vaccination for pneumococcal pneumonia and annual vaccination for influenza. Consistent with the

Department's strategic plan goals and through the collaborative efforts of CMS, CDC, and the National Coalition for Adult Immunization (NCAI), CMS is working to improve adult immunization rates in the Medicare population.

Performance Measure: Increase annual influenza (flu) and lifetime pneumococcal vaccination - FLU.		
	Target	Actual
FY 2002	72%	12/03
FY 2001	72%	12/02
FY 2000	N/A	70.4%
FY 1999	N/A	69.3% (includes community dwelling beneficiaries only)

(Source: MCBS)

Performance Measure: Increase annual influenza (flu) and lifetime pneumococcal vaccination — PNEUMOCOCCAL.		
	Target	Actual
FY 2002	66%	12/03
FY 2001	63%	12/02
FY 2000	N/A	62.7%
FY 1999	N/A	61.7% (includes community dwelling beneficiaries only)

(Source: MCBS)

The performance measures on adult immunizations (annual influenza and lifetime pneumococcal) are examples of CMS' promotion of preventive health. The current data source for this goal is the Medicare Current Beneficiary Survey (MCBS), which includes institutionalized beneficiaries.

Although FY 2000 MCBS data indicate continued progress toward the FY 2001 targets, interim 2001 National Health Interview Survey (NHIS) data show a decline in influenza vaccinations for adults 65 years and older. This decrease reflects the temporary shortage and delays that affected influenza vaccine distribution in 2000 and 2001. Pneumococcal vaccination rates continue to increase, according to interim 2001 NHIS data. Final FY 2001 MCBS data from vaccination rates will not be available until early FY 2003.

The CMS intends to increase the percentage of Medicare women age 65 and over who receive a mammogram every two years. By taking advantage of the lifesaving potential of mammography, the hope is to ultimately decrease mortality from breast cancer in the Medicare population. Women age 65 and over face a greater risk of developing breast cancer than younger women, and a disproportionate number of breast cancer deaths occur among older African-American women. Encouraging breast cancer screening, including regular mammograms, is critical to reducing breast cancer deaths for these populations.

The CMS' current (FY 2001 and FY 2002) mammography measure is based on the 1999 Health Plan Employer Data Information Set (HEDIS®) measure for breast cancer screening. Recently, the National Committee for Quality Assurance (NCQA) revised its technical specifications for the breast cancer screening measure and reported the updated definition in the HEDIS® 2002 technical specifications.

Performance Measure: Increase biennial mammography rates (NHIS).		
	Target	Actual
FY 2001	Switched to new data source (see below)	N/A
FY 2000	60%	68.1%
FY 1999	59%	66.8%

(Source: NHIS)

Performance Measure: Increase biennial mammography rates (National Claims History File).		
	Target	Actual
FY 2002	52%	8/03
FY 2001	51%	51.6%
FY 2000	N/A	50.5%

(Source: CMS' National Claims History File)

Final 2000 NHIS data show that CMS surpassed its FY 2000 target of 60 percent of women age 65 and older to receive a biennial mammogram by reaching 68.1 percent (the FY 2000 target was measured using NHIS data). CMS also surpassed its FY 2001 target of 51 percent of women age 65 years and older to receive a mammogram by reaching 51.6 percent. FY 2001 marks the first year CMS used Medicare claims data (National Claims History File) to measure this goal.

Prior research has shown that many beneficiaries are not well informed about the basic features of Medicare. In 1999 the MCBS asked a sample of beneficiaries whether people covered by Medicare could select among different kinds of health plans within Medicare. Forty-seven

percent correctly answered "true," 11 percent incorrectly answered "false," and 42 percent said they were not sure.

The purpose of this performance measure is not to turn every beneficiary into an expert on Medicare; consumer research has shown that beneficiaries generally seek information about the program only as specific needs arise. The objectives of this goal are:

- To improve awareness of the core features of Medicare that beneficiaries need to know to use the program effectively; and

- To improve beneficiary awareness of CMS sources from which additional information can be obtained if needed.

Performance Measure: Improve beneficiary understanding of basic features of the Medicare program (developmental).		
	Target	Actual
FY 2002	Baselines/future targets to be developed	Data being analyzed. Baselines /target data will be available by the end of CY 2002.
FY 2001	1) Develop list of core features 2) Obtain advisory input 3) Design and test survey questions 4) Integrate questions 5) Field questions	Steps 1-5 completed. Survey fielded.

(Source: CMS' Medicare Current Beneficiary Survey)

To promote beneficiary and public understanding of CMS and its programs, the above measure is being developed to improve beneficiary awareness of: 1) the core features of Medicare needed to use the program effectively; and 2) CMS sources from which additional information can be obtained. In FY 2001, CMS met the goal of completing actions necessary to field the MCBS from which baselines and targets for this measure are being developed in FY 2002. Once the data from the survey are analyzed, the baselines are expected by the end of calendar year 2002 on which to set future targets.

Medicaid

Centers for Medicare & Medicaid Services (CMS)

The Program

The Medicaid program was established in 1965 under Title XIX of the Social Security Act, is a federal-state partnership intended to provide healthcare to vulnerable populations. Medicaid is jointly financed by the federal and state governments (including the District of Columbia and the territories), and the program is administered by the states within broad federal statutory and regulatory parameters.

Results and Explanation of Performance

Consistent with the Department's strategic goal of creating new, affordable health insurance options, the Secretary has launched the Health Insurance Flexibility and Accountability (HIFA) and Pharmacy Plus waiver initiatives. These waiver demonstration initiatives give states new flexibility to tailor their programs to expand health insurance coverage for low-income individuals.

The HIFA initiative enables states to use Medicaid and SCHIP funds to coordinate with private insurance and re-design benefit packages and cost sharing in ways that best serve the needs of its citizens in a cost-effective manner. The Department encourages states to use HIFA to develop broad, statewide approaches that maximize private health insurance coverage options and target Medicaid and SCHIP resources to populations with income below 200 percent of the Federal Poverty Level. The HIFA waiver template - which is available electronically - allows streamlined application and review processes. To date, HIFA waivers have been approved for Arizona, California, Colorado, Illinois, Maine, New Mexico, and Oregon.

Pharmacy Plus waivers allow states to offer Medicaid prescription drug coverage to elderly and/or disabled individuals who are not otherwise eligible for Medicaid. The goal of Pharmacy Plus demonstrations is to assist individuals in maintaining their healthy status and avoid spending down to Medicaid income and asset eligibility levels. States are encouraged to use modern, private sector benefit management techniques to ensure that Pharmacy Plus is a cost effective approach to providing pharmaceutical benefits. Pharmacy Plus is also a mechanism that states can use now to provide seniors with prescription drug coverage while Congress develops a Medicare drug benefit. Four states have approved Pharmacy Plus waivers (Florida, Illinois, South Carolina, and Wisconsin) and Maryland has revised its statewide 1115 demonstration to add a pharmacy benefit. These approved waivers will provide access to prescription drug coverage for 769,000 individuals when fully implemented.

Since January 2001, HHS has approved more than 1,500 Medicaid and SCHIP waivers and plan amendments that have expanded eligibility to over two million people and enhanced benefits for more than six million enrollees.

Three groups of states, staggered over four years, will develop state-specific baselines, methods, and 3-year targets to increase childhood immunization rates for their states' Medicaid 2-year olds. All 16 Group I states have completed development of their methodologies, baselines, and 3-year targets. For FY 2001, 15 of the 16 have reported on their progress; the final state will report in January 2003. For FY 2002, 5 of the 16 states reported their second re-measurement.

The ten Group II states made excellent progress during their developmental period. These states have defined their state-specific methodologies and all have set their baseline and 3-year target rates. Two of the 10 states reported their first re-measurement for FY 2002.

Recruitment efforts for the final group of states (Group III) have been successful and these states are working on defining their state-specific measures during their developmental period.

Performance Measure: Increase the percentage of Medicaid 2-year-old children who are fully immunized.		
	Target	Actual
Group I States	Staggered development of state-specific baselines and targets.	FY 2002, 5 of 16 States reporting. FY 2001, 15 of 16 States reporting.
Group II States	States establish baselines and targets.	All States in group established baselines and targets.
Group III States	Recruit States	Recruitment successful.

(Source: CMS Financial Report, Fiscal Year 2002)

We are committed to assisting interested states in developing methodologies and conducting pilot studies to reduce Medicaid payment error rates. The FY 2002 target was to conduct a pilot payment accuracy study working with nine states. The data from these studies would be used to help refine payment accuracy measurement methodologies and assess the feasibility of constructing a single methodology usable by all states. No accepted methodology for Medicaid payment accuracy measurement now exists and only a handful of states have done work in this area. The FY 2002 goal was met as nine states developed payment accuracy methodologies as part of their participation in the pilot study.

Performance Measure: Assist states in conducting Medicaid payment accuracy studies for the purpose of measuring and ultimately reducing Medicaid payment error rates.		
	Target	Actual
FY 2002	9 States conduct pilot payment accuracy study.	Met target.

(Source: CMS Financial Report, Fiscal Year 2002)

State Children's Health Insurance Program

Centers for Medicare & Medicaid Services (CMS)

The Program

The Balanced Budget Act of 1997 created the State Children's Health Insurance Program

(SCHIP). This program makes an unprecedented investment toward improving the quality of life for millions of vulnerable, uninsured, low-income children. The statute authorizes and appropriates an annual amount that CMS grants to states and territories with an approved SCHIP plan. States were given the option to expand their Medicaid program, establish a separate SCHIP program or a combination of both. Currently, all states and territories have approved SCHIP plans. Many states are submitting plan amendments and 1,115 waivers to further expand insurance coverage under SCHIP.

Results and Explanation of Performance

Enacted through the Balanced Budget Act of 1997, the SCHIP, under Title XXI of the Social Security Act, allocates nearly $40 billion over ten years to extend health care coverage to low-income, uninsured children. SCHIP enables states to establish separate SCHIP programs, expand existing Medicaid programs, or use a combination of both approaches. Although estimates of insurance coverage for children vary, the Bureau of Census' annual March health insurance supplement to the Current Population Survey (CPS) is the most widely cited source. The CPS data for 1999 suggested that there were approximately ten million children under the age of 19 who lacked health insurance coverage. Approximately one-third of uninsured children are eligible for Medicaid and are not enrolled in the program.

Performance Measure: Increase the number of children enrolled in regular Medicaid or SCHIP.		
	Target	Actual
FY 2002	+1,000,000 over FY 2001	12/02
FY 2001	+1,000,000 over FY 2000	Additional 3,441,000
FY 2000	+1,000,000 over FY 1999	Additional 1,679,000
FY 1999	Develop goal; set baseline and targets.	21,980,000 (baseline)

(Source: CMS' automated Statistical Enrollment Data System [SEDS])

The implementation of SCHIP has stimulated enormous growth in the availability of health care coverage for children. The energy invested by states and territories, communities, and the Federal government has resulted in significant expansions in coverage, as well as new systems for enrolling children. The CMS and the states exceeded the FY 2001 goal to enroll an additional 1,000,000 children in SCHIP or Medicaid over the previous year's level. In fact, due to overwhelming success of the program, 3,441,000 children were enrolled over FY 2000 goal. The CMS expects to receive FY 2002 data in early 2003.

IHS Health Services – Hospital and Clinic Funding
Indian Health Service (IHS)

The Program

Hospital and Health Clinic funding, including insurance reimbursement (e.g. Medicare, Medicaid), supports comprehensive inpatient and ambulatory health care and support services such as nursing, pharmacy, laboratory, nutrition, and medical records provided in facilities run by Indian Health Service (IHS), Tribal, or Urban groups (I/T/U). This I/T/U system provides health care to over 1.4 million people at 568 health care delivery facilities, including 49 hospitals, 219 health centers, seven school health centers and 293 health stations, satellite clinics, and Alaska village clinics.

IHS continues to focus funding on evidence-based treatment and prevention strategies in addressing those health conditions that disproportionately affect American Indian/Alaskan Natives (AI/AN) such as diabetes, obesity, and heart disease among others. In the face of growing population and health care inflation, IHS has been successful in achieving many of its performance measures such as managing diabetes by keeping blood sugar under control as well as conducting necessary diabetic screenings; improving pap smear and mammography rates among eligible women; reducing injury-related mortality among AI/AN; and maintaining 100 percent accreditation of all IHS-run hospitals. Performance is illustrated below.

Results and Explanation of Performance

Performance Measure: Increase the proportion of I/T/U clients with diagnosed diabetes that have improved their glycemic control.		
	Target	Actual
FY 2002	Revised: target to be FY 2001 actual rate, or less.	06/2003
FY 2001	Improve from FY 2000	30%
FY 2000	Improve from FY 1999	26%
FY 1999	25%	24%

(Source: Annual IHS Diabetes Care and Outcomes Audit)

Diabetes continues to be an escalating problem in many AI/AN communities with rates increasing in several areas, age at diagnosis occurring at younger ages, and no sign of decline. The IHS Diabetes Program selected five treatment measures because of its proven benefits in reducing the morbidity and mortality associated with this condition. Blood sugar control or glycemic control is a key element of diabetic care aimed at reducing diabetic complications and is measured through a blood test called Hemoglobin A1c. Glycemic control can be achieved through healthy lifestyle practices and glucose lowering medications. As a result of such interventions, IHS is finding that the proportion of diabetics who have “Ideal” glycemic control has increased from 24 percent in FY 1999, to 26 percent in FY 2000, and to 30 percent in FY 2001. IHS will conduct the Annual Diabetes Care and Outcomes Audit, a chart review of 19,000 randomly selected charts in I/T/U facilities in Summer 2003 to determine performance on FY 2002 measures.

Performance Measure: Assure that the unintentional injury-related mortality rate for AI/AN people is no higher than FY 2001 rate.		
	Target	Actual
FY 2002	Revised: target to be FY 2001 actual rate, or less.	Not Available
FY 2001	No target	---
FY 2000	No target	---
FY 1999	95.84/100,000	95.5/100,000

(Source: Official injury mortality data from the National Center for Health Statistics [NCHS])

Injuries are a leading cause of hospitalization for AI/AN people relative to morbid events. Annually, 46 percent of the Years of Potential Life Lost (YPLL) for AI/AN people are the result of injuries. Furthermore, injuries are the number one cause of mortality for AI/AN people for ages 1- 44 years and third for overall death rates. In response to the major public health problem, the IHS has assigned an Injury Prevention Program Manager, in the Office of Public Health, at headquarters who coordinates activities and resources with specially trained Injury Prevention Specialists at the area, district, service unit, and tribal levels.

This program employs a community empowerment model and is directed to build tribal capacity to recognize severe injury problems and employ evidence-based strategies to prevent or otherwise control injury outcomes. The Complete Injury Prevention Program model developed by IHS is the cornerstone of community-based intervention measures.

Most unintentional injuries are related to motor vehicle crashes. Significant improvements can be made in these statistics with increasing in use of occupant protection (safety belts and child safety seats), reducing pedestrian/motor vehicle collisions and alcohol-related injuries through multiple strategies including corrections in the physical environment, changes in tribal policies, and health promotion/education. These injury measures are identified in the *Healthy People 2010* Objectives and are relatively easy to measure. Other new initiatives are targeting childhood fire-related deaths through the *Sleep Safe* program in conjunction with Head Start school programs, and continue to work with partners such as the CDC, the National Highway Traffic Safety Administration, the Maternal and Child Health Bureau at HRSA, and the U.S. Fire Administration.

In most recent GPRA submission, the IHS reported that the indicator addressing Unintentional Injury Mortality for FY 1999 was not achieved because the data for AI/AN revealed a mortality rate of 95.5/100,000 while the target was 93/100,000. However, the reported data for FY 1999 is not comparable with previous years because it used the new International Classification of Disease version 10 (ICD-10) system while the previous recent years used the ICD-9 version.

To deal with this problem, the National Center for Health Statistics published comparability ratios in the September 21, 2001 issue of National Vital Statistic (Deaths: Final Data for 1999) which provide adjustments to compare data based on the ICD-9 system with the ICD-10 system.

When the performance target of 93/100,000 is adjusted for the ICD-10 system using the published comparability ratio of 1.0305 for unintentional injuries, the target becomes 95.84/100,000 or less. Since the rate was 95.5/100,000 (based on the ICD-10), the target was met.

Performance Measure: Maintain 100 percent accreditation of all IHS hospitals and outpatient clinics.		
	Target	Actual
FY 2002	100%	100%
FY 2001	100%	100%
FY 2000	100%	100%
FY 1999	100%	100%

(Source: IHS compiled database generated from accreditation reports submitted by IHS Area Quality Assurance coordinators.)

The accreditation of IHS hospitals and clinics conducted by the Joint Commission on the Accreditation of Health Care Organizations (JCAHO) is a well-respected measure of health care quality. Accreditation is also essential for maximizing third-party collections. IHS has in place local I/T/U multidisciplinary teams which provide support and ongoing quality management to continue success in this performance measure. Since 1999, IHS has maintained 100 percent accreditation of its IHS-run facilities.

Ryan White HIV/AIDS Program
Health Resources and Services Administration (HRSA)

The Program

The Ryan White Comprehensive AIDS Resources Emergency (Ryan White CARE Act) Act programs, authorized by Title XXVI of the Public Health Service Act, fund the provision of HIV medical care and related services for low income and medically underserved persons. There are four major titles of the Ryan White CARE Act. Title I, the HIV Emergency Relief Grants (Part A), provides funding to eligible metropolitan areas disproportionately impacted by the HIV epidemic for the provision of ambulatory outpatient health and support services. Title II, HIV CARE Act Grants to states (Part B), provides formula grants to states, the District of Columbia and islands and territories for the purpose of providing health care and support services for people living with HIV disease. A separate earmark under Part B provides funding for HIV/AIDS therapies through the AIDS Drug Assistance Program (ADAP). Title III funds programs that provide early intervention services. Title IV funds HIV Pediatric Grants. The Ryan White CARE Act also provides funding for AIDS Education Training and Dental Reimbursement.

The HRSA's HIV/AIDS Bureau administers the Ryan White CARE Act in partnership with state and local governments as well as other community-based providers and academic institutions.

Results and Explanation of Performance

All titles of the Ryan White CARE Act have demonstrated good program performance as seen in the example performance measures included below.

Performance Measure: Serve a proportion of racial/ethnic minorities in Title I-funded programs that exceeds its representation in national AIDS prevalence data, as reported by CDC, by a minimum of 5 percentage points.		
	Target	Actual
FY 2002	70%	1/2004
FY 2001	69%	1/2003
FY 2000	64%	70.4%
FY 1999	64%	68.9%

(Source: CDC Year-End HIV/AIDS Surveillance Report and Ryan White CARE Act Data Report)

Despite the reduction in overall AIDS mortality, annual incidence data shows the proportion of AIDS cases among minorities continues to increase. In addition, benefits provided by new combination drugs have not uniformly reduced the disparities in the incidence of AIDS. Latino and African-American HIV patients are significantly more likely to initiate drug therapy late, compared to Caucasian patients. The proportion of racial/ethnic minorities served in Title I programs was selected as the best measure of the program's goal to eliminate disparities among individuals infected with HIV/AIDS by increasing utilization for traditionally underserved populations.

The Title I-funded programs are serving a significantly higher proportion of minorities than the target specified in the performance goal. Trend data demonstrate excellent program performance. In 1998, CDC estimates 55.8 percent of AIDS cases were minorities; 67.7 percent of Title I clients were minorities - a difference of 11.9 percentage points. In 1999, CDC estimates 57 percent of AIDS cases were minorities; 68.9 percent of Title I clients were minorities - a difference of 11.9 percentage points. Finally, in 2000, CDC estimates 57.3 percent of AIDS cases were minorities; 70.4 Title I cases were minorities - a difference of 13.1 percentage points. It is anticipated that HRSA will achieve performance targets for FY 2001 and FY 2002.

The ADAP program provides therapeutics to treat HIV disease or prevent the serious deterioration of health arising from HIV disease. Therapeutics provided by ADAP include anti-retrovirals, medications for the treatment and prevention of opportunistic infections and ancillary and tertiary medications to address side effects caused by HIV medications. The ADAP program's ability to provide medications to underserved populations has improved significantly. For example, from 1997 to 2001, the number of state ADAP programs participating in the Section 340B Drug Discount Program increased from 19 to 50. Savings from cost-recovery strategies increased from $24.4 million in 1997 to a projected $65.5 million in 2001.

Performance Measure: Increase the number of ADAP clients receiving HIV/AIDS medications during at least one month of the year (through state ADAPs).		
	Target	Actual
FY 2002	84,800	02/2004
FY 2001	72,000	73,784
FY 2000	71,900	70,357
FY 1999	NA	62,881

(Source: ADAP Monthly Report)

In FY 2001, 73,784 persons were served at least one month of the year by ADAP, exceeding the FY 2001 performance target of 72,000. In comparison with figures from FY 2000, an additional 3,427 clients were receiving drug therapies through ADAP during at least one month in FY 2001. Many clients are enrolled in ADAP only temporarily while they await acceptance into insurance programs such as Medicaid.

National Health Service Corps
Health Resources and Services Administration (HRSA)

The Program

The National Health Service Corps (NHSC) program assists health professional shortage areas to meet its primary, oral, and mental health services needs. Over its 30-year history, the NHSC has offered recruitment incentives such as scholarships and loan repayment support to more than 22,000 health professionals committed to serving the underserved. For example, NHSC provides a culturally competent workforce for federally-funded Health Centers and other sites which find it difficult to recruit clinicians. Over 50 percent of the NHSC field strength serve in Health Centers.

Over its 30-year history, the NHSC has offered recruitment incentives such as scholarships and loan repayment support to more than 22,000 health professionals committed to serving the underserved.

Results and Explanation of Performance

Performance Measure: Increase the percent of clinicians retained in service to the underserved.		
	Target	Actual
FY 2002	76%	4/2003
FY 2001	75%	80%
FY 2000	74%	75%
FY 1999	72%	70.1%

(Source: NHSC Annual Retention Report)

Retention of NHSC clinicians preserves access to care for the underserved beyond the period of service commitment. According to the NHSC 2001 Annual Retention Report, 80 percent of NHSC clinicians, in an interview after completion of service commitment, report remaining in service to the underserved, substantially exceeding the FY 2001 performance target. Retention has grown steadily from the mid-50 percent range in FY 1995.

An NHSC program evaluation entitled "Evaluation of the Effectiveness of the National Health Service Corps" (May 31, 2000) indicates that more than half of the NHSC clinicians who completed its service commitments between 1983 and 1997 are currently in service to the underserved. The program plans to measure retention at one year after service obligation and follow cohorts of clinicians over their working lives to assess retention at longer intervals.

Maternal and Child Health Block Grant
Health Resources and Services Administration (HRSA)

The Program

The purpose of the Maternal and Child Health (MCH) Block Grant program, as authorized under Title V of the Social Security Act, is to improve the health of all mothers and children, including children with special health care needs. Created as a partnership with state Title V programs which have broad state discretion, the MCH Block Grant appropriated formula grant funds are used for a number of activities including; capacity and systems building, public information and education, outreach and program linkage, support for newborn screening, lead poisoning and injury prevention, support services for children with special health care needs (CSHCN), and the promotion of health and safety in child care settings.

> Health insurance coverage plays an important role in assuring appropriate access to care for children with special health care needs.

Results and Explanation of Performance

Performance Measure: Increase the percent of CSHCN in the states' programs with a source of insurance for primary and specialty care		
	Target	Actual
FY 2002	91%	01/2004
FY 2001	90%	01/2003
FY 2000	NA	90.3%
FY 1999	NA	87%

(Source: Title V Electronic Reporting Package)

Health insurance coverage plays an important role in assuring appropriate access to care for CSHCN. Nearly one in ten children with special health care needs, 1.3 million, are uninsured. These children are four times more likely than insured children to have unmet needs for health care and related services. More than one-fourth of uninsured CSHCN have no physician contact over the course of a year. Since children are more likely to obtain health care if they are insured, the above measure is an important indicator of access to care. Increasing the percentage of insured CSHCN is accomplished through a combination of outreach to children eligible but not enrolled in public programs such as SCHIP, and assisting families to obtain insurance in the private sector.

Currently, the majority of CSHCN (55 percent) receive coverage through private policies, while one-third are covered by either Medicaid or SCHIP. The number of CSHCN with a source of insurance for primary and specialty care has been increasing steadily since 1997 and is consistent with performance targets for FY 2001 and FY 2002.

Rural Health
Health Resources and Services Administration

The Program

HRSA's Office of Rural Health Policy (ORHP) is the only office in the Department solely concerned with the rural health care needs of the Nation. It is active in coordinating rural health care programs and policies within HRSA, with CMS, and with other Federal Departments such as the Department of Agriculture and the Department of Housing and Urban Development. The ORHP also provides leadership for the Secretary's Rural Task Force. Programs administered by ORHP include Rural Health Policy Development, Rural Health Outreach Grants, Rural Access to Emergency Devices, Rural Hospital Flexibility Grants, State Offices of Rural Health and the Denali Project.

Results and Explanation of Performance

Performance Measure: Assist rural facilities in converting to Critical Access Hospital status.		
	Target	Actual
FY 2002	240	657
FY 2001	222	500

(Source: Medicare Rural Hospital Flexibility Grant Program Tracking Team)

The Rural Hospital Flexibility Grant Program was established by Congress to provide support to America's smallest and most vulnerable rural hospitals. Grants are awarded to states to: 1) develop and implement a state rural health plan; 2) designate Critical Access Hospitals that will be eligible for cost-based payments through the Medicare program; 3) assist these Critical Access Hospitals and the communities they serve in developing networks of care; 4) improve rural Emergency Medical Services; and 5) improve the quality of care provided in rural communities.

Conversion of appropriate rural facilities to Critical Access Hospital status will help sustain the rural health care infrastructure to provide access to high quality care for rural Medicare beneficiaries. This is a core component of the Medicare Rural Hospital Flexibility Program. Meeting statutory requirements for certification and Condition of Participation for Critical Access Hospitals enables the hospital to be reimbursed on the basis of reasonable cost.

This improves the financial performance of these vulnerable facilities, thereby sustaining access. In FY 2001 and FY 2002, HRSA substantially exceeded targeted performance levels. As of August, 2002 the number of conversions has climbed to 657.

Health Centers
Health Resources and Services Administration (HRSA)

The Program

The Health Center program, a major component of America's health care safetynet for the nation's indigent populations, is leading a Presidential initiative to increase health care access for those Americans who are most in need. Health centers, operating at the community level through a federal, state, and community partnership approach, provide regular access to high quality, family oriented, comprehensive primary and preventative health care, regardless of ability to pay. Health centers improve the health status of underserved populations living in inner cities and rural areas. The Health Center Presidential Initiative is combining past successes with new activities, such as medical capacity expansion, to broaden the health center safetynet and increase access to primary health care for the nation's underserved populations.

To eliminate health disparities, safetynet programs must target access to care for people of

racial/ethnic minority groups, people of low income and those who are uninsured. The performance measures below demonstrate the success of the health centers program in providing access to care for disadvantaged populations. In turn this will work toward the elimination of health disparities.

Results and Explanation of Performance

Performance Measure: Continue to assure access to preventative and primary care for low income individuals (i.e. at or below 200 percent of federal poverty level). Targets and actuals are numbers of clients, in millions.		
	Target	Actual
FY 2002	86% - 10.11 million	8/2003
FY 2001	86% - 9.03 million	88% - 9.07 million
FY 2000	86% - 8.26 million	87% - 8.35 million
FY 1999	86% - 7.65 million	86% - 7.65 million

(Source: UDS Health Center data)

According to Uniform Data System (UDS) Health Centers data, 88 percent or 9.07 million patients were at or below 200 percent of the federal poverty level in 2001. Sixty-seven percent were below poverty and 21 percent were between 100 and 200 percent poverty, exceeding the FY 2001 performance target. The number of clients at or below 200 percent poverty has been rising over the six years for which there is available data. The percentage of clients at or below 200 percent poverty is also rising.

Performance Measure: Continue to assure access to preventative and primary care for racial/ethnic minority individuals.		
	Target	Actual
FY 2002	65% - 7.64 million	8/2003
FY 2001	65% - 6.84 million	64% - 6.62 million
FY 2000	65% - 6.24 million	64% - 6.18 million
FY 1999	65% - 5.79 million	64% - 5.70 million

(Source: UDS Health Center data)

According to UDS Health Center data, in FY 2001 the population served included 25 percent African American, 35 percent Hispanic, and 4 percent Asian/Other, for a total of 64.3 percent, less than one percentage point below the performance target. The number of minority clients has increased from 6.18 million in FY 2000 to 6.62 million in FY 2001. It is currently estimated that both the numbers and percentage of minority clients will increase. HRSA projects achievement of the FY 2002 performance target. It should be noted that since the total number of health center clients is increasing, the number of minority clients will have to increase at a much greater rate

in order to increase the percentage. For example, the number of minority clients increased by 7.2 percent between FY 2000 and FY 2001, but there was no change in the percentage of health center clients who are minority individuals.

Nursing Programs
Health Resources and Services Administration (HRSA)

The Program

HRSA's Bureau of Health Professions currently administers programs which collectively address Nursing Workforce Development: Advanced Education Nursing (Section 811 of the Public Health Service Act); Nursing Workforce Diversity (Section 821 of the Public Health Service Act); Nurse Education, Practice and Retention Grants (Section 831 of the Public Health Service Act); and the Nursing Education Loan Repayment Program (Section 846(h) of the Public Health Service Act). All the nursing programs are engaged in efforts to combat the current nursing shortage.

Results and Explanation of Performance

Performance Measure: Award nursing loan repayment contracts		
	Target	Actual
FY 2002	560	12/2002
FY 2001	200	443
FY 2000	200	195
FY 1999	200	202

(Source: Prime Care)

HRSA's FY 2002 GPRA report includes performance measurement for only the Nursing Education Loan Repayment Program (NELRP). Performance for the other nursing programs is aggregated with all Title VII and Title VIII health professions programs. HRSA is currently examining the feasibility of establishing separate performance measures for the programs associated with Nursing Workforce Development.

The NELRP focuses on providing service-obligated registered nurses for not less than two years at a health facility with a critical shortage of nurses. The NELRP provides an economic incentive to RNs to practice in rural or urban communities with a shortage by repaying up to 85 percent of eligible outstanding education loans. In 2001, an additional $5 million was transferred into the program and 443 loan repayment contracts were negotiated.

Faith-Based and Community Initiatives

The Program

The mission of the HHS Center for Faith-Based and Community Initiatives (CFBCI) is to create an environment within the Department that welcomes the participation of faith-based and community-based organizations (FBO/CBO) as valued and essential partners with the Department in assisting Americans in need. CFBCI's mission is part of the HHS focus on improving human services for our country's neediest. CFBCI is the leader of the Department's efforts to better utilize FBO/CBO in providing effective human services.

To meet the challenge, ACF, HRSA, and SAMHSA have included specific performance measures in their GPRA plans to track the program participation of faith and community-based organizations.

Results and Explanation of Performance

I. Administration for Children and Families (ACF)

As part of the HHS faith-and community-based management improvement initiative, ACF proposed tracking the number of applications received in FY 2002, increasing outreach efforts, assessing the quality of applications, and providing a technical assistance plan for the grant programs shown below. Because there was no OMB approved data collection instrument for tracking applicants, ACF instead created a baseline of FY 2001 grants awarded to FBO/CBO, using ACF administrative data.

FY 2001 Performance Indicator: The percentage of faith-based and community-based organizations (FBO/CBO) funded by selected discretionary grant programs.		
Programs	FY 2001	Baseline
Urban/Rural Community Economic Development	100%	Legislation requires that all grantees must be Community Development Corporations
Assets for Independence	90%	Eight of the 81 grantees are county or city governments, the rest are FBO/CBO
Adoption Opportunities	50%	Of 67 grantees, 33 are FBO/CBO, 32 are state or local governments and 2 are universities
Runaway and Homeless Youth Programs	100%	All 634 grantees are FBO/CBO

Since FBO/CBO are currently the primary recipients of discretionary grant funds in three of the four selected areas, ACF will focus on technical assistance efforts in future program performance measurement.

II. Substance Abuse and Mental Health Services Administration (SAMHSA)

SAMHSA's Programs of Regional and National Significance (PRANS) are ensuring that FBO/CBO have equal access to funding opportunities. SAMHSA has developed performance measures on the receipt of FBO/CBO applications, quality of applications, and technical

assistance participation. The establishment of baseline information for these performance measures is dependent on OMB clearance of the necessary information collection forms.

III. Health Resources and Services Administration (HRSA)

HRSA's Health Centers, Abstinence Education and HIV Early Intervention programs intend to measure program performance for the FBO/CBO initiative. HRSA's grant announcements and grant application guidance invite all interested and qualified FBO/CBO to apply for HRSA funding opportunities.

These programs have established performance measures to increase the number of grant applicants that are faith-based organizations or community-based organizations. Upon OMB approval of an information collection instrument, baselines will be established.

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

HHS is committed to strengthening the base of qualified health and behavioral science researchers to advance the understanding of basic biomedical and behavioral science, whereby, NIH, the world's largest and most distinguished organization dedicated to maintaining and improving health through medical science, is leading the efforts to meet these objectives as well as advancing the understanding of basic biomedical and behavioral science.

HHS is also committed to accelerating the private sector development of new drugs, biologic therapies, and medical technology.

FDA's Medical Devices and Radiological Health Program is responsible for ensuring the safety and effectiveness of medical devices and eliminating unnecessary human exposure to manmade radiation, of which, pre-market review is a major program component. The medical device industry is growing rapidly and devices submitted for review are becoming increasingly complex. These programs have annual performance measures which speak to enhancing the capacity and productivity of the nation's research enterprise. These programs also serve as examples of how HHS continues to seek enhancement in Health Science Research.

National Institutes of Health Research Program
The National Institutes of Health (NIH)

The Program

Founded in 1887, the NIH is the federal focal point for medical research in the United States. NIH funds research on diseases and conditions ranging from the rarest genetic disorder to the common cold. NIH supports research of non-federal scientists in universities, medical centers, hospitals, and research institutions throughout the country and abroad; conducts research in its own laboratories; helps to train research investigators; and fosters communication of medical information to the public, health care providers, and the scientific community.

Medical innovation is one of the principal foundations on which America's past successes in improving healthcare have been built. It is where hope for the future resides. History provides abundant evidence that medical progress rarely occurs without the sustained pursuit of advances in basic and behavioral science. Through the conduct and support of medical research, NIH seeks to expand fundamental knowledge of living systems; to improve and develop new strategies for the diagnosis, treatment, and prevention of disease; and to reduce the burdens of disease and disability.

NIH invests the public's resources and support for medical science in three basic and interrelated ways. First and foremost, NIH conducts and supports medical research. Second, it contributes to the development and training of the pool of scientific talent. Third, it participates in the support, construction, and maintenance of the laboratory facilities necessary for conducting cutting-edge research.

Results and Explanation of Performance

The availability of the genome sequence of humankind marks the starting point of the genome era in biology and medicine. There is now much important work to do to deliver on the promise that these advances in genomics offer for human health.

The Human Genome Project is already producing results that will have an effect on human health. By the end of FY 2002, The International Human Genome Sequencing Consortium finished (accuracy of at least 99.99 percent) over 88 percent of the human genome. The essentially complete sequence of the human genome is expected to be achieved in FY 2003. The "Book of Life", as some have termed the human genome, is actually three books: a history book narrating the human species' journey through time; a shop manual providing the parts list and detailed blueprint for building every human cell; and a transformative textbook of medicine which provides insights, giving health care providers immense new power to treat, prevent, and cure disease.

NIH also awarded a contract at the end of FY 2001 for a pathogen functional genomics resource center, which will provide the research community with resources and reagents for functional analysis of microbial pathogens and invertebrate vectors of infectious diseases. In FY 2002, NIH developed additional initiatives including a program of grant supplements to facilitate the application of innovative/emerging technologies (frequently genomic technologies) to current funded research projects related to the study of infectious diseases, diseases caused by category A agents of bioterrorism, HIV/AIDS, basic immunology, and immune-mediated conditions.

In 2001, there were three million deaths worldwide due to AIDS, making it the fourth leading cause of mortality. Worldwide, 40 million were living with HIV/AIDS during 2001 and roughly five million people became newly infected with HIV, about 14,000 per day. Therefore, the development of a safe and effective HIV vaccine is a global public health imperative. Since the beginning of the epidemic, NIH's comprehensive research program has made significant progress in elucidating the structure of HIV, determining how it attacks the immune system, understanding the role of the immune system in controlling HIV, developing new and improved

models for testing candidate vaccines, and in sponsoring and conducting clinical trials.

Advances in the design and development of vaccine strategies continue to fuel the pipeline of promising HIV/AIDS vaccine candidates. Notable scientific progress was made in FY 2002 including the initiation of a Phase I clinical trial to evaluate an HIV-1 DNA vaccine encoding a modified Gag-Pol protein in uninfected adult volunteers. Two new epidemiologic and observational studies were also initiated to evaluate the HIV viral characteristics and the immunologic response of vaccine volunteers who acquire HIV after enrolling in HIV vaccine studies and international recruitment and retention strategies for high-risk individuals. NIH has fostered national and international collaborations to expand the evaluation of vaccine products and continues to work with the HIV Vaccine Trials Network to expand the capabilities and the capacity of international sites in preparation for future large efficacy trials in the Americas, Africa, and Asia. In response to the critical need for an HIV vaccine, the National Institute of Allergy and Infectious Diseases continues to advance basic science programs, clinical research initiatives, and production capabilities.

NIH disseminates new knowledge resulting from research as broadly as possible to increase public awareness. To achieve this goal, NIH is focusing on: 1) enhancing NIH operations to improve the communication of research results; 2) strengthening collaborations with other organizations involved in health communications; 3) developing and implementing communication campaigns on specific health issues; and 4) increasing the public's awareness of specific health issues and the role of NIH.

NIH continued to partner with other organizations in FY 2002, meeting its targets to increase public awareness and access to the latest scientific and health information. Performance results included: 1) progress in development of an easily navigable Web site to increase older adults' awareness of health information; 2) a stroke education campaign, *Know Stroke. Know the Signs. Act in Time.*, which includes community education materials, public service messages, and media outreach; and 3) development of materials for a campaign about the importance of calcium from milk and other sources.

NIH is committed to increasing the number of physicians and other clinicians trained to conduct patient-oriented research, and in 1999, NIH implemented three new career mechanisms to achieve this important goal. The two mechanisms that still are active - K23s (Mentored Patient-Oriented Research Career Development Awards), which support young investigators and K24s (Mid-career Investigator Award in Patient-Oriented Research) - are components of the Director's Initiative on Clinical Research.

The two award mechanisms appear to be attractive to potential applicants. In FY 2002, NIH issued 197 new K23s, greatly exceeding the target of 120 awards, and 48 K24s, somewhat fewer than the expected steady-state. The K24 results suggest that the pool of mid-career patient-oriented research mentors may be reaching saturation. However, NIH still expects the K24 mechanism to continue to facilitate increases in the number of productive scientists working in this important area.

Human Drugs Program– Pre-Market Review
Food and Drug Administration (FDA)

The Program

The mission of FDA's Human Drugs Program is to promote the public health by assuring that safe and effective drugs are available to the American people. The Human Drugs Program reviews all new drug and generic drug applications; works on developing over-the-counter (OTC) medication and increasing the range of OTC products available on the market; increases the availability of drugs adequately labeled for children; and assures the availability of drugs to treat persons exposed to biological, chemical, or radiological agents as a result of a terrorist attack.

As a result of the major reform brought by the Prescription Drug User Fee Act (PDUFA), FDA has significantly shortened review times without compromising patient safety. Under PDUFA, FDA has approved over 30 new medicines for Cancer, and 37 medicines for AIDS, among others. They have also increased the range of generic drugs on the market, which saves the American public and government $8 billion to $10 billion each year according to the Congressional Budget Office. In FY 2001, FDA approved the generics for Prozac and Pepcid. The following section illustrates how FDA continues to improve review times for New Drug Applications (NDA) without sacrificing the safety and quality of new and generic drugs.

Results and Explanation of Performance

Performance Measure: Review and act on standard original NDA submission within 12 months of receipt.		
	Target	Actual
FY 2002	90%	mid-FY 2003
FY 2001	70%	1/2003
FY 2000	50%	79% of 92
FY 1999	30%	66% of 95

(Source: Center-wide Oracle Management Information System [COMIS]; New Drug Evaluation/Management Information System [NDE/MIS])

Performance Measure: Review and act on priority original NDA submissions within 6 months.		
	Target	Actual
FY 2002	90%	mid-FY 2003
FY 2001	90%	100% of 10
FY 2000	90%	97% of 29
FY 1999	90%	100% of 31

(Source: Center-wide Oracle Management Information System [COMIS]; New Drug Evaluation/Management Information System [NDE/MIS])

A major objective of the human drugs program is to reduce the time required for FDA's review of all drugs. Emphasis is given to the review of priority new drugs intended to provide a significant therapeutic or public health advance, which treat serious or life-threatening diseases such as AIDS, AIDS-related diseases, cancer, and heart disease (many cases resulting from obesity).

With such financial support from user-fees, the Center for Drug Evaluation and Research has met and exceeded its targets in standard new drug applications since FY 1999 and has exceeded its FY 2001 performance goal for priority new drug applications. Overall, review times are decreasing. Approval times for priority applications have decreased from 15 months in 1994 to six months in 2001. For standard applications, review times have decreased from 22.1 months to 14 months during the same time period.

Performance Measure: Review and act upon fileable generic drug applications within 6 months after submission date.		
	Target	Actual
FY 2002	65%	mid-FY 2003
FY 2001	50%	84% of 298
FY 2000	45%	55.6% of 307
FY 1999	60%	28% of 309

(Source: Center-wide Oracle Management Information System- COMIS; New Drug Evaluation /Management Information System - NDE/MIS)

FDA exceeded its goal for FY 2001 acting on 84 percent of 298 original applications within six months after the submission date. FDA has approved over 7,000 generic drugs for various treatments, including benign prostatic hyperplasia, various ovarian and breast cancers, and high blood pressure. The agency continues to examine every aspect of the review process to try to identify problem areas as well as refine the review process to increase efficiency. FDA has increased the number of electronic submissions. FDA utilized funding increases in FY 2001 to annualize positions as well as hire and train new staff, particularly chemistry reviewer which has increased productivity.

Medical Devices, Pre-Market Review
Food and Drug Administration (FDA)

The Program

The Medical Devices and Radiological Health Program is responsible for ensuring the safety and effectiveness of medical devices and eliminating unnecessary human exposure to manmade radiation from medical, occupational, and consumer products, of which pre-market review is a major program component. Medical device manufacturers must seek FDA clearance or approval of their products to ensure that marketed devices meet tough safety regulations. The medical device industry is rapidly growing and devices submitted for review are becoming increasingly complex. Some of the devices approved in FY 2001 include the first Automated External Defibrillator (AED) for children, implants for the treatment of extreme obesity, and the first glucose monitoring device that does not puncture the skin.

Results and Explanation of Performance

Performance Measure: Review and act on 90 percent of pre-market approval applications of an estimated 80 first actions within 180 days.		
	Target	Actual
FY 2002	90%	mid-FY 2003
FY 2001	90%	97% of 70
FY 2000	85%	96% of 67
FY 1999	65%	74% of 43

(Source: Center for Devices and Radiological Health Premarket Tracking System and Receipt Cohorts)

Pre-market approval applications are often high-risk devices, which can significantly improve patient treatment. FDA anticipates growth in the number of applications and complexity. Many new devices incorporate computer technology which will require more sophisticated review skills. In fact, 40 percent of pre-market approval applications are breakthrough technologies and 25 percent are from first time applicants. These external factors present a significant human capital challenge in adding time to the review process.

In FY 2001, FDA performance was 97 percent for applications received in FY 2001. FDA applied a risk management strategy to the review process in redirecting resources from low-risk to high-risk devices.

Performance Measure: Review and act on 90 percent of pre-market approval applications supplement final actions within 180 days.		
	Target	Actual
FY 2002	90%	mid-FY 2003
FY 2001	90%	98.4% of 641
FY 2000	85%	98.7% of 545
FY 1999	N/A	N/A

(Source: Center for Devices and Radiological Health Premarket Tracking System and Receipt Cohorts)

These supplements are generally added features to already approved devices or technology changes. FDA continues to offer manufacturers the option of "real time" reviews, which are conducted via teleconference or face to face and enable manufacturers to discuss all FDA review issues at one time. In FY 2001, sponsors of over 25 percent of the 641 pre-market approval application supplements chose real-time reviews, mostly by teleconference. Overall FY 2001 performance was 98.4 percent for applications received in FY 2001.

Strategic Goal 5: Improve the Quality of Health Care Services

This goal aims to improve the quality of health care services by reducing medical errors, improving consumer and patient protection, and accelerating the development and use of electronic health information. The programs discussed in this section illustrate HHS' commitment to health care research; upholding health, safety and quality standards in institutions that serve Medicare and Medicaid beneficiaries; and modernizing electronic health information for the ultimate outcome of improving patient safety and health care quality.

The Agency for Health Care Research and Quality (AHRQ) continues to be at the forefront of health care quality research in promoting improvements in clinical health systems and practices. The CMS continue to focus its efforts on improving the quality of care of CMS beneficiaries in nursing homes. Both the FDA and IHS are committed to enhancing IT capacity in order to track and prevent medical errors and improve health care quality overall. FDA continues to improve its adverse event surveillance capabilities and in-house medical error tracking systems. IHS continues to enhance its IT system and use of electronic patient information, which enables IHS to provide quality health care to individual patients, as well as track population health statistics.

Research on Health Care Quality and Outcomes

Agency for Healthcare Research and Quality (AHRQ)

The Program

The AHRQ promotes health care quality improvement by conducting and supporting health services research that develops and presents scientific evidence regarding all aspects of health

care. The agency's mission is to improve the outcomes and quality of health care services through a broad base of scientific research and through the promotion of improvements in clinical and health systems practices, including the prevention of diseases and other conditions. AHRQ is a key participant in the Secretary's Prevention Initiative and the 21st Century Health Care Initiative for electronic health care. AHRQ is also pursuing multiple research strategies toward the improvement of patient safety.

Patient safety is a top priority in the nation today. The Institute of Medicine report entitled, *To Err is Human*, estimated that between 44,000 and 98,000 people die each year in hospitals from medical errors. The majority of these errors are the result of systemic problems rather than poor performance by individual providers. Although the United States provides some of the best health care in the world, the number of patients being harmed as a result of the process of health care is unacceptably high. The goal of the Department's patient safety initiative is to reduce the risk of injury and harm from medical errors. This goal can be accomplished by removing or minimizing hazards that increase the risk of injury to patients.

Results and Explanation of Performance

The Patient Safety Initiative was developed in FY 2001. In FY 2002, AHRQ increased the investment in patient safety by awarding more than 20 additional grants and contracts related to the patient safety initiative. The funded projects form an integrated set of activities to design and test best practices for reducing errors in multiple settings of care and will develop the science base to inform those who must implement programs and policies regarding the most effective approach. Categories of ongoing grants and contracts include: 1) identifying risks and hazards; 2) building capacity; 3) raising awareness; and 4) identifying proven patient safety practices.

The results of this ongoing investment in patient safety research are now being incorporated into practice. For example, the HHS Patient Safety Task Force commissioned a study to provide recommendations for integrating the patient safety reporting systems of the Department. The results are being used to begin the integration of the reporting systems.

In addition, to help patients assess the safety of their care, AHRQ, CMS, and other organizations supported the National Quality Forum (NQF), a not-for-profit membership organization created to develop and implement a national strategy for health care quality measurement and reporting. The NQF developed a list of serious, avoidable, adverse events that are so significant and so preventable that their occurrence should trigger an investigation of the organization in which they occurred. This list is now completed and available to the public at www.qualityforum.org.

AHRQ research has provided information about 73 proven patient safety practices to health care administrators, medical directors, health professionals, and others who are responsible for patient safety programs. Voluntary Hospitals of America and Premier, Inc., use the information to guide its member hospitals in selecting projects to improve safety. Many chief executive officers, medical directors, and hospital safety officers have also reported using the information to initiate projects to improve patient safety.

Examples of patient safety projects funded in FY 2002 and now in progress include:

- *Shared Online Health Records for Patient Safety and Care*. This three-year project is assessing the impact on patient care and safety of tools for electronic patient-provider communication and shared online health records. The researchers are investigating to determine whether:
  - medication safety improved with patient prompts and a shared patient/physician medication list;
  - patient prompts, reminders, and entries in an online system improve chronic disease outcomes and adherence to guidelines in health care maintenance and chronic disease;
  - prompted patient family history assessment improve detection of familial risk factors; and
  - electronic communication and the shared use of the online system by patients; and physicians impact on medical practice, and how might barriers be addressed.

- *Improving Patient Safety by Examining Pathology Errors*. This research is focusing on anatomic pathology diagnostic errors and their effects on patient outcomes. Previous studies have been limited to single institutions and reported variable diagnostic error percentages from less than one percent to 43 percent of all patients who underwent a biopsy or excisional procedure, with no correlation between error and outcome. This project is establishing a web-based, pathologist driven, national, voluntary anatomic pathology error database. The data will be used for continuous quality improvement targeted at error reduction and clinical outcomes improvement. Reporting institutions will receive quality performance reports relating to errors and outcomes at their facilities. Specific factors associated with increased risk for diagnostic error will be identified. Analyses will be performed to determine potential sources of errors, and error reduction programs will be implemented at each institution. This project will provide valuable information regarding diagnostic pathology errors and will lay the groundwork for future studies on other types of diagnostic pathology error and the effects of error reduction programs in pathology practice.

Nursing Home Quality - State Survey & Certification Program
Centers for Medicare & Medicaid Services (CMS)

The Program

The state Survey and Certification program ensures that institutions providing health care services to Medicare and Medicaid beneficiaries meet federal health, safety, and quality standards. As part of the Nursing Home Oversight Improvement Program, surveyors have been instructed to pay particular attention to nursing homes' use of physical restraints and to their ability to prevent and treat pressure ulcers.

The Survey and Certification program includes funds to strengthen and continue activities focused on ensuring that CMS beneficiaries in nursing homes receive quality care in a safe environment. Nursing home patients are a vulnerable population group, susceptible to complications and morbidities resulting from physical restraints and pressure ulcers. The

performance measures to decrease the use of physical restraints and the prevalence of pressure ulcers represent CMS' focus on ensuring quality of care in long-term care facilities.

Results and Explanation of Performance

Physical restraints refer to any manual method, mechanical device, material, or equipment attached or adjacent to the patient that the individual cannot remove easily and that restricts freedom of movement or normal access to one's body. Restraints should be used only when required to treat medical symptoms and should never be used as a substitute for adequate patient supervision. The use of physical restraints can cause incontinence, pressure sores, loss of mobility, and other morbidities. Many providers and consumers still mistakenly hold, however, that restraints are necessary to prevent residents from injuring themselves.

Performance Measure: Decrease the Prevalence of Restraints in Nursing Homes.		
	Target	Actual
FY 2002	10%	9.9% (Interim Data)
FY 2001	10%	10%
FY 2000	10%	10%
FY 1999	14%	11.9%

(Source: CMS' OSCAR Database)

The CMS' efforts to reduce the use of physical restraints through the state Survey and Certification Program have been successful. Use of restraints in nursing homes has decreased from 17.2 percent in 1996 to 9.9 percent in 2001. Although CMS has achieved a large reduction in the use of physical restraints, it is believed that current program efforts are achieving smaller reductions in restraint use than previously. Future reductions in restraint use, while important, will likely be more difficult to achieve. The CMS will continue to stress restraint reduction as a program goal, maintaining the target at 10 percent while evaluating the effect of current policies and consider the introduction of new ones.

Pressure ulcers refer to any lesion caused by pressure resulting in damage of underlying tissues, often referred to as bedsores. Pressure ulcers are an undesirable outcome that can be prevented in most residents except those at very high risk.

Use of restraints in nursing homes has decreased from 17.2 percent in 1996 to 9.9 percent in 2001.

Performance Measure: Decrease the Prevalence of Pressure Ulcers in Nursing Homes.		
	Target	Actual
FY 2002	9.5%	10.3% (Interim Data)
FY 2001	9.6%	10.5%
FY 2000	N/A	9.8%
FY 1999	N/A	N/A

(Source: CMS' Minimum Data Set [MDS] Database)

The CMS is still concerned about the increase in pressure ulcers, and reducing the prevalence over the FY 2000 baseline and about the gap between the target and the measured rate. CMS believes that this increase in prevalence may stem in part from a number of factors and is working to address those issues. Interim FY 2002 data indicate the prevalence of pressure ulcers is 10.3 percent (target 9.5 percent). The CMS is developing a program to educate providers about more accurate assessment and coding, as well as new protocols aimed at onsite audit procedures that will verify the accuracy of nursing homes' MDS assessments.

Information Technology for Hospitals, Pharmacies, and Health Care Providers
Food and Drug Administration and Indian Health Service (FDA & CMS)

The Program

A key element of this strategic goal is the development of an electronic health information infrastructure to improve patient care and especially, patient safety. In particular, AHRQ as discussed earlier in this section, FDA, and IHS are some of the HHS operating divisions (OPDIVs) which are developing technology to prevent medical errors.

FDA is well known for its postmarket regulatory role in tracking the effectiveness and safety of medical devices, human drugs and biologics on the market. This program is also linked to Strategic Goal 2 in that such IT systems help the agency respond to public health challenges. In order to improve the quality of care for patients, FDA continues its efforts to maintain its Adverse Event Reporting Systems (AERS) database where physicians and others report any adverse reactions to drugs or therapeutic biological products. Medical Device Surveillance Network (MeDSuN), another adverse event system, is actually placed in several health care facilities and tracks injuries or deaths attributed to use or misuse of medical devices.

> FDA puts substantial effort into reviewing adverse event and medication error reports to identify serious or potentially serious outcomes that might be avoided by modifying the labeling or packaging or other means.

Results and Explanation of Performance

FDA Performance Measure: Streamline Adverse Drug Event reporting system (AERS).		
	Target	Actual
FY 2002	Accepting electronic submission from companies and be current with MedDRA coding versions.	mid-FY 2003
FY 2001	Issue proposed rule on adverse event reporting requirement, Issue guidance on electronic submission of adverse event reports. Grant waivers to companies wishing to submit adverse events electronically. Continue AERS development – post 2.0. Roll out of AERS datamart to medical officers in new drug review divisions.	AERS version 2.1 (Compliance) completed. 11,000 individuals safety reports submitted electronically. AERS versions 2.2 (Electronic Submissions) and 2.3 (Data Entry) both implemented.
FY 2000	Develop next generation of AERS to enhance functionality.	Development and roll-out of AERS was completed. Pilot program to increase participation in electronic expedited reporting ongoing. Regulation requiring that adverse event reports be precoded using MedRA on target for release for public comment this FY.
FY 1999	Implement AERS for the electronic receipt and review of voluntary and mandatory ADR reports	The AERS was successfully implemented and has been operational for nearly three years.

(Source: AERS and Drug Quality Reporting System)

The Center for Drug Evaluation and Research uses a number of approaches to assess the safety of drug products once released on the market such as AERS, "Dear Colleague" letters, MedWatch where health care professionals and consumers are encouraged to report serious adverse events, among others to ensure the continued safe use of drug products. Approximately 1.3 million patients each year are injured from medical therapy with up to two-thirds of these events due to medical management errors. The Institute of Medicine estimates that as many as 100,000 Americans die annually as a result of preventable medical errors. As more medical products become available, the number of medical errors could increase.

In calendar year 2001, FDA received over 285,000 reports of suspected drug related adverse events for entry into AERS. Seventy percent represented serious or unexpected events. The agency puts substantial effort into reviewing adverse event and medication error reports to identify serious or potentially serious outcomes that might be avoided by modifying the labeling or packaging or other means. If necessary, FDA disseminates "Dear Healthcare Professional" letters or takes regulatory action. FDA is also coordinating with Medical Device contractors in implementing a "drug" MeDSuN where health professionals in user facilities can input adverse drug events.

In terms of further enhancing the software, FDA completed the next generation of the IT system - AERS version 2.1 (compliance) and AERS versions 2.2 (electronic submissions) and 2.3 (data entry) were implemented. Additionally, 11,000 individuals safety reports were submitted electronically, which enhances efficiency by cutting back the number of paper submissions.

FDA Performance Measure: Enhance the MeDSuN System by implementing Drugs and Biologics training in recruited hospitals.		
	Target	Actual
FY 2002	Implement MeDSuN by recruiting a total of 80 facilities for the network.	mid-FY 2003
FY 2001	Recruit a total of 75 hospitals to report adverse medical device events	FDA began feasibility testing with 25 hospitals and worked on software changes needed for website health data security.
FY 2000	Develop MeDSuN based on approximately 25 user facilities.	Develop MeDSuN Phase II Pilot based on approx. 25 user facilities.
FY 1999	Implement Pilot	Pilot completed

(Source: Center for Device and Radiological Health Adverse Events Reports)

In order to determine the level of injuries and deaths associated with medical device usage or mis-usage, FDA continues to work towards developing a representative network of medical device users by recruiting and enrolling health care facilities to report device usage. In FY 2001, FDA did not meet its goal of recruiting 75 hospitals. Much effort was focused on addressing heightened technology security requirements. During the past year, FDA extended software development to accommodate an Internet-based reporting system (interactive web-based form and database), and took steps to ensure that reporters had internet access to secure servers. FDA did recruit 25 hospital facilities. Throughout FY 2002, FDA sought to add more facilities, and projects recruiting a total of 80 facilities for the network.

IHS utilizes an integrated health information system throughout its health care delivery network. This system, which is known as Resource Patient Management Information System (RPMS), consists of an integrated suite of clinical, administrative, and financial software applications. This system enables IHS to provide quality health care to individual patients as well as track population health statistics. The RPMS supports individual clinical endeavors through applications that include, for example, immunization tracking, diabetes case management, and pharmacy; these diverse but integrated applications result in an individual electronic patient health summary. This summary is used by the providers to track clinical information as well as guide medical care decisions.

IHS monitors population health by using aggregate data retrieved primarily from RPMS, but to a lesser extent from other healthcare information systems. This data enables IHS to track clinical quality. Quality is measured by pre-determined guidelines (e.g. *Healthy People 2010* measures, GPRA, HEDIS – measures which track health care quality in managed care organizations), and reports are available for review at a local, regional and national level.

IHS Performance Measure: Expand the automated extraction of GPRA clinical performance measures and improve data quality.		
	Target	Actual
FY 2002	Assess five sites for five performance measures	Assessments completed.
FY 2001	Set up five sites for testing five performance measures	Five sites for testing five performance measures established
FY 2000	No measure	Not applicable
FY 1999	No measure	Not applicable

(Source: Resource Patient Management System [RPMS] clinical data)

This measure is part of an ongoing effort to improve the overall accuracy, completeness, and timeliness of clinical data from the agency's primary clinical data repository - RPMS Patient Care Component used for GPRA clinical measures. IHS continues to emphasize the value of 'transparent' data extraction for providers in health care facilities. Data is being collected at the national level that will allow electronic reporting on a number of clinical measures, for example, the following measures for individuals with diabetes: blood pressure control, annual dental and dilated eye exams, and glycemic control (i.e., Hemoglobin A1C levels). Additionally, changes are being made in how data is collected and stored at the national level to allow us to begin examining other measures and deriving additional information important to managing our programs. These changes include: modifications in the RPMS export program to allow the collection of additional data; improved monitoring of the export process; initial development of a new state-of-the-art data warehouse and associated data marts; and additional tools to assess and help improve data quality. In addition, IHS developed and deployed a new software application, GPRA+, in FY 2002, which allows health care providers at the local level to track its progress on various clinical GPRA measures. This application, coupled with ongoing efforts to improve clinical data quality, should result in increasingly reliable, accurate, and timely data.

This measure was met and serves as part of a long-term effort to expand the IHS capacity to derive GPRA performance data directly from clinical automated information systems as opposed to work-intensive chart audits currently used for the Diabetes Care Audit. This will allow IHS to add new performance measures in the most cost-effective way, without imposing additional data collection burdens on health care staff. It will also support other IHS management efforts - including delivering high quality clinical care, managing programs, quality improvement, monitoring epidemiological trends, and performing clinical research. IHS completed a pilot

study to assess the quality and accuracy of performance data. For example, RPMS data on childhood heights and weights have a greater than 97 percent accuracy when compared to the written chart and were at least as good as the written chart in classifying children as normal, at risk, or overweight.

A web-based training tool has been developed and is currently being tested at five IHS locations, which will assist providers in improving its chart documentation and data quality. Facility providers can see how they are performing with regard to data quality and chart documentation for five GPRA indicators and be able to compare its scores with other participating sites. Preliminary data gathered during FY 2002 from sites for which web-based training and reporting has been provided reveal:

- Two percent increase in percent of women age 18 - 45 years receiving a pap smear in the prior 15 months (63.4 percent to 65.8 percent);

- Five percent increase in percent of children age 24 - 35 months who have completed the recommended ACIP immunization series (39.3 percent to 44.1 percent);

- Four percent increase in the percent of adult patients with diabetes who have received a pneumococcal vaccine (62.4 percent to 66.2 percent); and

- Two percent increase in the percent of adults 65 years or older who have received a pneumococcal vaccine (56.6 percent to 58.6 percent).

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

HHS has continued to support efforts to increase the independence of low income families, welfare recipients, the disabled, older Americans, Native Americans and Refugees.

The HHS programs, detailed below, have annual performance measures that speak to improving the economic and social well-being of individuals, families, and communities. These measures serve as examples of how HHS has improved the economic and social well-being of individuals, families, and the communities.

Temporary Assistance for Needy Families
Administration for Children and Families (ACF)

The Program

The purposes of the Temporary Assistance for Needy Families (TANF) program are to: 1) provide time-limited assistance to needy families; 2) reduce dependency by promoting job readiness, work and marriage; 3) prevent out-of-wedlock pregnancies; and 4) encourage the formation and maintenance of two-parent families. Under Title IV-A of the Social Security Act, as amended by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996

(PRWORA), states and territories receive a block grant allocation and are required to operate its own programs, determining eligibility and benefit levels and services offered. Tribes have this option, as well.

The primary goal of the TANF legislation is to move recipients from welfare to work and self-sufficiency. In partnership with states, ACF has achieved unprecedented levels of performance in moving families from welfare to work, as evidenced by the performance measures below.

Results and Explanation of Performance

Performance Measure: All states meet the TANF all-families work participation rate (FYs 2002-2003 - 50 percent; FY 2001- 45 percent).		
	Target	Actual
FY 2002	100%	09/2003
FY 2001	100%	100%
FY 2000	100%	100%
FY 1999	100%	100%

(Source: TANF administrative data)

Performance Measure: All states meet the TANF two-parent families work participation rate (Rate - 90 percent).		
	Target	Actual
FY 2002	100%	09/2003
FY 2001	100%	88%
FY 2000	100%	76%
FY 1999	100%	74%

(Source: TANF administrative data)

The above work participation standards were established by PRWORA. All states have been meeting the all-family goal but the two-parent family goal of 90 percent work participation for all states remains unmet. In FY 2001, 86 percent of the states with two-parent family programs met the 90 percent work participation target. This is an extremely rigorous standard.

It should be noted that the average number of Americans receiving cash assistance each month has declined from a high of 14.4 million in 1994 to 5.0 million in 2001, a reduction of over 65 percent.

Performance Measure: Increase the percentage of adult TANF recipients who become newly employed.		
	Target	Actual
FY 2002	43%	09/2003
FY 2001	43%	12/2002
FY 2000	42%	46.4%
FY 1999	-	43.3%
FY 1998	-	38.7%

(Source: National Directory of New Hires)

In FY 2000, there was a 3.1 percentage point increase in the percent of adult TANF recipients who became newly employed. The success states had in moving TANF recipients to work in FY 2000 can be attributed to several factors including the employment focus of PRWORA, ACF's commitment to identify, research and disseminate information on the effects of alternative employment strategies and a range of targeted technical assistance efforts.

Low-Income Home Energy Assistance Program
Administration for Children and Families (ACF)

The Program

The purpose of the Low Income Energy Assistance Program (LIHEAP) is to assist low-income households that pay a high proportion of household income for home energy to meet its immediate needs. States, federally or state-recognized Tribes/Tribal organizations, and Insular areas receive federal LIHEAP block grants to administer the program at the community level. The LIHEAP statute targets two priority groups of low-income households needing energy assistance: 1) vulnerable households, i.e. households with at least one member who is elderly, disabled, or a young child; and 2) high energy burden households, i.e. households with the lowest incomes and highest energy costs.

Results and Explanation of Performance

LIHEAP grantees are required by law to conduct outreach activities designed to assure that eligible households, especially vulnerable high home-energy-burden households, are made aware of LIHEAP assistance. Approximately 3.6 million houses received heating assistance in FY 2000, representing about 12 percent of all households with incomes under the federal maximum LIHEAP income standard (29.4 million households).

About 34 percent of households receiving heating assistance included at least one elderly member; 40 percent of all low-income households have at least one elderly member. About 36 percent of households receiving heating assistance included at least one adult member who was unable to work due to illness or disability; 18 percent of all low-income households have at least one ill or disabled member. About 21 percent of households receiving heating assistance

included at least one child under six years of age; 18 percent of all low-income households have at least one child under six years of age. (Source: Bureau of the Census' March 2000 Current Population Survey)

The figures cited above indicate that LIHEAP funds are being effectively targeted to the disabled, somewhat effectively targeted to households with young children and less effectively targeted to households with elderly members. ACF has established a targeted outreach project which includes the federal dissemination of a brochure providing information about LIHEAP benefits. The ACF and other HHS OPDIVs will assist in the distribution of this brochure to targeted populations. Participation by the community-based networks of the Administration on Aging should greatly enhance efforts to target elderly households.

Social Services Block Grant
Administration for Children and Families (ACF)

The Program

The purpose of the Social Services Block Grant (SSBG) is to provide states with a flexible pool of resources to meet the changing needs of children and families. The program was established under Title XX of the Social Security Act, as amended by Pub. L. 97-35. Funds are allocated to states on the basis of population and support outcomes across the human services spectrum. The SSBG outcomes align with several of ACF's strategic goals including employment, child care, child welfare, adoptions and youth services. The SSBG resources give states the ability to target services in areas of greatest need, depending on state and local priorities.

State services funded by SSBG must be directed at one or more broad social policy goals: 1) achieving or maintaining economic self-support to prevent, reduce, or eliminate dependency; 2) achieving or maintaining self-sufficiency, including reduction or prevention of dependency; 3) preventing or remedying neglect, abuse, or exploitation of children and adults unable to protect their own interests or preserving, rehabilitating, or reuniting families; 4) preventing or reducing inappropriate institutional care by providing for community-based care, home-based care, or other forms of less intensive care; and 5) securing referral for institutional care when other forms of care are not appropriate or providing services to individuals in institutions. The program performance measures discussed below are examples of the wide-ranging array of services that may be provided under the SSBG.

Results and Explanation of Performance

Performance Measure: Increase by 1 percent over prior year the number of child recipients of day care services funded wholly or in part by SSBG funds.		
	Target	Actual
FY 2002	plus one percent	12/2003
FY 2001	2,399,827	3,150,776
FY 2000	-	2,834,703
FY 1999	-	2,620,938
FY 1998	-	2,399,827

(Source: SSBG Post-expenditure Reports)

This performance measure will be discontinued after FY 2002, to be replaced by a broader performance measure of child care which will include children receiving child care services through TANF-direct and the Child Care Development Fund (CCDF) as well as SSBG. Trend data demonstrate that the number of children receiving day care with some SSBG funding has been increasing at a rate well in excess of one percent per year.

Performance measure: Maintain at the FY 1998 baseline the number of recipients of child protective services funded wholly or in part by SSBG funds.		
	Target	Actual
FY 2002	1,302,895	12/2003
FY 2001	1,302,895	1,411,427
FY 2000	Not applicable	1,081,446
FY 1999	Not applicable	1,312,736
FY 1998	Not applicable	1,302,895
FY 1997	Not applicable	1,037,860

(Source: SSBG Post-expenditure Reports)

The FY 2001 performance target was achieved. However, trend data shows some fluctuation from year to year. The flexibility provided states in using SSBG funds results in variations of expenditures across service categories from one year to the next. Recently, ACF has revised its post-expenditure form to improve the consistency of reporting among states and reduce discrepancies in reporting methodology. States will begin using this improved form for FY 2002 expenditures.

Community-Based Services Programs
Administration on Aging (AoA)

The Program

The AoA's Community-Based Services Program (CBSP) provides grants to states to provide comprehensive social and supportive services to vulnerable elderly individuals and their family caregivers. AoA has carried out the CBSP through a national aging network that includes 56 state Units on Aging, 655 Area Agencies on Aging, 236 Indian Tribal Organizations, and over 29,000 public, private, and voluntary direct service providers.

The CBSP provides to older Americans "access" services, such as information and assistance, outreach, transportation; "community" services, which include congregate meals, senior-center activities, adult day care, pension counseling, health promotion and fitness programs; "in-home" services, including home-delivered meals, chores, home maintenance assistance, home-health, and personal care; "caregiver" support, such as respite services.

Results and Explanation of Performance

Performance Measure: A significant percentage of Older Americans Act (OAA) Title III service recipients live in rural areas.		
	Target	Actual
FY 2002	25%	02/2004
FY 2001	25%	02/2003
FY 2000	Not applicable	32.9%
FY 1999	Not applicable	33.6%

(Source: The National Aging Program Information System [NAPIS])

The AoA and the national aging network continue to help vulnerable elderly individuals maintain their independence in the community and avoid institutionalization in facilities such as nursing homes.

In FY 1999 and FY 2000 over one-third of CBSP clients live in rural areas, compared to less than one-quarter for the total population age 60 and above.

Performance Measure: Maintain a high ratio of leveraged funds to AoA funds		
	Target	Actual
FY 2002	$ 1.50 to $1.00	02/2004
FY 2001	$ 1.50 to $1.00	02/2003
FY 2000	Not applicable	$ 1.90 to $1.00
FY 1999	Not applicable	$ 1.90 to $1.00

(Source: The National Aging Program Information System [NAPIS])

In FY 1999 and FY 2000, states and local entities leveraged almost $2 in funding from other sources for every dollar AoA provides for CBSP. This clearly shows that the Aging Network is committed to providing a greater range of services and increasing access among the elderly population.

Sanitation
Indian Health Service (IHS)

The Program

The IHS Sanitation Facilities Construction (SFC) Program is an integral component of the IHS disease prevention activity and has provided American Indians and Alaskan Natives (AI/AN) potable water and waste disposal facilities since 1960. As a result of such activities, infant mortality rates for gastroenteritis and other environmentally related diseases have decreased by 80 percent since 1973. IHS, in collaboration with Tribes and other agencies, designs and builds water connections and solid waste facilities in those areas that are economically feasible and in need. In FY 2001, IHS continued to address sanitation and clean water needs. Currently, 92.5 percent of AI/AN homes have safe water in the home compared with 99 percent of all U.S. homes. Navajo and Alaska, in particular, face some of the largest deficiencies with only 83 percent of Navajos and 65 percent of Alaskan Natives having safe water in the home. IHS continues to achieve its annual goal to provide sanitation facilities to new and existing homes and work towards its long term goals to significantly reduce clean water and sewage deficiencies by 2010 in the face of population growth.

The IHS Sanitation Facilities Construction (SFC) Program is an integral component of the IHS disease prevention activity and has provided American Indians and Alaskan Natives (AI/AN) potable water and waste disposal facilities since 1960.

Results and Explanation of Performance

Performance Measure: Provide sanitation facilities to new or like-new homes and existing facilities.		
	Target	Actual
FY 2002	2,528 - New./LNew 12,727 - Existing Total - 15,255	FY 2003
FY 2001	3,800 - New/LNew 10,930 - Existing Total - 14,730	3,551 - New/LNew 14,451 - Existing Total - 18,002
FY 2000	3,740 - New/LNew 11,035 - Existing Total - 14,775	3,886- New/LNew 14,490 - Existing Total - 18,376
FY 1999	5,900 - New/LNew 9,330 - Existing Total - 15,230	3,557 - New/LNew 13,014 - Existing Total - 16,571

(Source: SFC Sanitation Deficiency System [SDS] and Project Data System [PDS])

The FY 2001 performance measure significantly exceeded. The program provided sanitation facilities to 3,551 new or like-new homes and 14,451 existing homes for a total of 18,002 homes served by the end of FY 2001, which exceeds the total target of 14,730 homes. The significant increase in existing homes was the result of allocating more funding towards the upgrade of existing community sanitation facilities infrastructure. IHS Sanitation program is successful in leveraging funding, which impacts performance. Since 1996, IHS has received annually between $30 million to $44 million from outside contributors such as the Environmental Protection Agency (EPA) and the Department of Housing and Urban Development (HUD). Additionally, its collaborative efforts with agencies at all levels, including efforts to improve fund transfer mechanisms, joint environmental review processes, and tribal community planning capacities has further strengthened program performance.

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

HHS is taking significant steps to improve the development and learning readiness of preschool children through the Head Start and Child Care programs. The Child Support Enforcement program is working to increase the financial support provided by non-custodial parents and to encourage their involvement in the lives of their children. Child Welfare and Youth programs are striving to assure that vulnerable children and youths are living in safe, permanent environments.

HHS programs demonstrate through its aggressive performance goals and annual program performance achievement the Department's commitment to this strategic goal. The evidence of strong program performance in the examples cited below documents improvement in the

stability and development of our nation's children and youth.

Head Start and Early Head Start
Administration for Children and Families (ACF)

The Program

The Head Start program provides grants to local public and private non-profit and for-profit agencies to provide comprehensive child development services to children and families. Intended primarily for pre-school age children in low-income families, Head Start promotes school readiness by enhancing the social and cognitive development of children through the provision of educational, health, nutritional, social and other services. In FY 2002, 1,565 grantees served 915,114 children in Head Start programs (including Early Head Start).

In FY 1995, the Early Head Start program was established in recognition of the mounting evidence that the earliest years, from birth to three years of age, matter a great deal in children's growth and development. In FY 2002, Early Head Start grants were awarded to approximately 775 projects, which served more than 62,000 children under the age of three.

Results and Explanation of Performance

Performance Measure: Increase the percentage of Head Start children who receive necessary medical treatment after being identified as needing medical treatment.		
	Target	Actual
FY 2002	94%	01/2003
FY 2001	92%	88%
FY 2000	90%	88%
FY 1999	88%	87%

(Source: PIR)

Because healthy children are better able to learn, Head Start works to ensure that every child is in a comprehensive health program that includes immunizations, medical, dental, mental health, and nutritional services. In FY 2001, 178,840 children (88 percent) received necessary health services, compared to 175,504 in FY 2000 and 166,500 in FY 1999. While Head Start did not achieve the aggressive performance target established for FY 2001, performance has been improving each year, as demonstrated by the increase in numbers of children receiving needed care. ACF expects FY 2002 performance information will demonstrate a continued high level of performance.

Head Start's Family and Child Experiences Survey, a longitudinal study, is showing encouraging results. The most current data (2000) indicate that Head Start children completing the program are achieving an average 32 percent gain in word knowledge compared to average gain among

all children during the pre-K year of 19 percent. In addition, Head Start children are achieving an average 43 percent gain in mathematical skills compared to the average gain for all pre-K children of 30 percent. Considering most Head Start children enter the program with scores below the norm on most measures of school readiness, these early indications of program performance are quite impressive.

Child Care
Administration for Children and Families (ACF)

The Program

The Child Care and Development Fund (CCDF) was established under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) to help working low-income families achieve and maintain self-sufficiency and to improve the overall quality of health care. Administered by ACF, in partnership with state and local governments, CCDF controls mandatory, matching, and discretionary (Child Care Development Block Grant) funds. TANF and SSBG are also used to support child care.

The Child Care Bureau partners with the Head Start Bureau and the Department of Education to enhance the quality of child care. Current collaborative efforts include implementation of the President's *Good Start, Grow Smart* initiative. ACF is also working with HRSA's Maternal and Child Health Bureau to sponsor the *Healthy Child America Campaign* to improve health and safety in child care.

Results and Explanation of Performance

Performance Measure: Increase the number of children served by CCDF subsidies (target number expressed in millions).		
	Target	Actual
FY 2002	2.2	09/2003
FY 2001	2.1	12/2002
FY 2000	1.92	1.74
FY 1999	Not applicable	1.65

(Source: ACF-800 and ACF-801)

The current performance measure cited above includes only those children served through CCDF subsidies, while excluding children served through non-CCDF funding streams including the SSBG and TANF-direct. As such, it understates the number of children receiving federally-subsidized child care. In future years this performance measure will be replaced by a measure which captures the number of children receiving child care services through CCDF, TANF-direct and SSBG funds. However, the current measure does illustrate the upward trend in the number of children served by ACF.

Performance Measure: Increase by 1 percent the number of regulated child care centers and homes accredited by a nationally recognized early childhood development professional organization.		
	Target	Actual
FY 2002	9,725	9/2003
FY 2001	9,630	9,237
FY 2000	-	9,535

(Source: National Association for Family Child Care, the National Association for the Education of Young Children, and the National School-Age Care Alliance)

The above performance measure is an indicator of quality. Accreditation of child care facilities has been linked to better outcomes for children and is increasingly accepted as a marker of good quality care. Several states use CCDF quality improvement funds to support accreditation for child care centers and homes.

Accreditation information comes from the National Association for Family Child Care, the National Association for the Education of Young Children, and the National School-Age Care Alliance. Targeted performance for FY 2001 was not achieved. ACF believes the shortfall occurred because the National Association for the Education of Young Children (NAEYC) has revised its accreditation standards and NAEYC is responsible for the majority of accreditations. For example, in FY 2000, 8,332 of the reported 9,535 total facilities/homes accredited were NAEYC accredited. ACF will examine how the revised accreditation process is likely to impact future program performance and revise projections accordingly. The FY 2002 performance target will probably not be achieved.

Child Support Enforcement
Administration for Children and Families (ACF)

The Program

The mission of ACF's Child Support Enforcement (CSE) program, established under Title IV-D (IV-D) of the Social Security Act, is to assure that assistance in obtaining support is available to children through establishing paternity and support obligations, locating parents, and modifying and enforcing those obligations. ACF's Office of Child Support Enforcement (OCSE) works in partnership with state and local governments to aggressively implement the program. CSE utilizes numerous tools such as the Federal Parent Locator Service, the National Directory of New Hires, and the Federal Case Registry which help to locate non-custodial parents and/or their employers. In addition, ACF partners with the Treasury Department to implement the IRS Tax Refund Offset program to offset income tax refunds of delinquent child support obligors; with the Justice Department to address criminal non-payment of support; and, with financial institutions to identify non-custodial parents assets. In addition, ACF plays a key role in the Department's effort to increase parental responsibility by promoting fathers' involvement in the lives of their children.

Results and Explanation of Performance

The CSE program broke new records nationwide in FY 2001, collecting $19 billion for child support.

The program has an incentive funding system employing five performance measures enacted by the Child Support Performance and Incentive Act of 1998 (CSPIA). The OCSE performance plan employs the same performance measures as those established under the CSPIA. Two representative performance measures are included below. It is important to note that early performance targets were developed under a prior reporting system where data validity standards were less rigorous and there were some differences in the definition of data elements.

Performance Measure: Increase the collection rate for current support.		
	Target	Actual
FY 2002	55%	09/2003
FY 2001	54%	57%
FY 2000	71%	56%
FY 1999	70%	53%

(Source: OCSE-157; OCSE-396Aand OCSE-34A)

Program performance for this goal is showing continued improvement as evidenced by the performance data provided above. To effect the achievement of this goal, ACF has employed numerous strategies which are focused on improved enforcement techniques and enhanced data reliability. Emphasis has been placed on automated mechanisms for enforcement, collections, and payments to families. The PRWORA has greatly enhanced enforcement efforts by providing states with improved mechanisms including new hire reporting, uniform procedures for interstate cases, centralized collection and disbursement and enhanced wage-withholding procedures.

This performance measure, serving as a proxy for the regular and timely payment of support, calculates performance by comparing total dollars collected for current support in IV-D cases to total dollars owed for current support in IV-D cases (collections for current support in IV-D cases divided by current support amount owed in IV-D cases). The total amount of child support distributed as current support in FY 2000 was $12.9 billion, approximately a nine percent increase over FY 1999. The total amount of current child support due in FY 2000 was $23 billion, roughly a two percent increase over FY 1999. This yields an FY 2000 collection rate for current support of 56 percent. For FY 2001, the total amount of child support distributed as current support was $14.2 billion; an increase of over ten percent. The total amount of current support due in FY 2001 was $24.7 billion, approximately a seven percent increase from FY 2000. The FY 2001 collection rate for current support is 57 percent, exceeding the performance target. As these figures demonstrate, since the amount of current support due is increasing, the amount of current support distributed must increase at an even greater rate in order to achieve an increase in the performance measure. It is important to note that support distributed has increased nine percent and ten percent for FY 2000 and FY 2001, respectively. ACF anticipates

achieving the FY 2002 performance target.

Performance Measure: Increase the Paternity Establishment Percentage among children born out of wedlock.		
	Target	Actual
FY 2002	97%	09/2003
FY 2001	96.5%	102%*
FY 2000	96%	95%
FY 1999	96%	106%*

*represents current paternity establishments and completion of backlog cases
(Source: OCSE-157, OCSE-396A and OCSE-34A)

Program performance under this goal is also at a high level. ACF has provided and/or supported and will continue to provide or support technical assistance, early interventions, and training and education activities to help individuals better understand their parental responsibilities. The above performance information demonstrates ACF's success toward achieving this goal.

This measure compares paternities established during the fiscal year with the number of non-marital births during the preceding fiscal year. Using the statewide Paternity Establishment Percentage, the above rates include paternities established by both the state IV-D program and hospital-based programs. States are handling current paternity establishment and handling backlogs of older IV-D cases needing paternity establishment. The number of children born out of wedlock with paternity established in FY 2001 was approximately 1.6 million, yielding a statewide paternity establishment percentage of 102 percent, substantially exceeding the FY 2001 performance target. ACF anticipates the FY 2002 performance target will be achieved.

Foster Care/Adoption Assistance/Child Welfare
Administration for Children and Families (ACF)

The Program

ACF administers an array of Child Welfare programs in partnership with state and local governments. The purposes of ACF's Child Welfare programs are to prevent maltreatment of children in troubled families, protect children from abuse, and find permanent placements for those children who cannot safely return to their homes. Programs such as Foster Care and Independent Living provide safe and stable environments for those children who cannot remain safely in their own homes. The Child Welfare Services and Promoting Safe and Stable Families programs provide services which focus on protecting children and strengthening families. When a child cannot be reunified with his/her family, programs such as Adoption Assistance, Adoption Incentives and Adoption Opportunities strive to place the child permanently with an adoptive family.
Results and Explanation of Performance

Performance Measure: Maintain the percentage of children who exit the foster care system through reunification within one year of placement.		
	Target	Actual
FY 2002	67%	06/2003
FY 2001	67%	68%
FY 2000	67%	65%
FY 1999	67%	63%

(Source: AFCARS)

Over 110,000 children (68 percent) who exited foster care through reunification did so within one year of placement. Detailed data analysis confirms that the time to reunification is accelerating. Provisions of the Adoption and Safe Families Act of 1997 (ASFA), particularly the change in timing of dispositional hearings from 18 months to 12 months, have directly affected program performance for this measure. In addition, this performance measure is included in the Child and Family Services reviews. It is anticipated that ACF will achieve the FY 2002 performance target.

Performance Measure: Increase the number of adoptions of children in the foster care system.		
	Target	Actual
FY 2002	56,000	09/2003
FY 2001	51,000	50,000
FY 2000	46,000	50,000
FY 1999	41,000	46,000
FY 1998	-	36,000
FY 1997	-	31,000

(Source: AFCARS)

In FY 2001, for the first time since before implementation of GPRA, ACF has failed to increase the number of adoptions of children in the foster care system and has fallen short of the annual performance target. This is because most of the children on the adoption track prior to the implementation of ASFA have now completed the adoption process. However, it is important to note that, for FY 1999 - FY 2001, the total number of adoptions exceeded performance targets by 8,000. ACF continues to strive for improved program performance in this area.

Strategic Goal 8: Achieve Excellence in Management Practices

HHS has been committed to improving the efficiency and effectiveness of the Department's programs and achieving the goals of the President's Management Agenda by creating an organization that is citizen-centered, market-based, and results-oriented. Included in HHS's many efforts has been the work to reduce erroneous payments, the dedication to maintaining clean opinions in HHS audited financial statements, the push to revitalize HHS's human capital management and through facilities improvement provide safe, modern, efficient and physically secure laboratories and support facilities in the most economical manner possible. For more detailed coverage of the President's Management Agenda, see Section I.

The following programs had annual performance measures that demonstrate results in achieving excellence in management practices and serve as examples of how HHS has made progress towards this strategic goal.

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

The Program

The Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191, HIPAA or the Act) created the Health Care Fraud and Abuse Control (HCFAC) program (at Section 1128C of the Social Security Act). The Act coordinated health care fraud enforcement activities in a single program, led by HHS and the Department of Justice (DOJ), and provided powerful new criminal and civil enforcement tools and resources to combat health care fraud.

The Act appropriated monies from the Medicare Trust Fund to the HCFAC Account in amounts that the Secretary and Attorney General jointly certified were necessary to finance anti-fraud activities. The maximum amounts available were specified in the Act. Certain of these sums were to be available only for the activities of the HHS Office of Inspector General (OIG).

The increased resources made available under HIPAA enabled OIG to enhance its efforts to both detect fraud, waste and abuse and to prevent it. Equally important, OIG's prevention activities reduced the government's enforcement costs and program losses.

Results and Explanation of Performance

The OIG HCFAC Program had one performance measure it developed and another it incorporated from its partnership with CMS.

OIG used Return On Investment (ROI) as a measure of its HCFAC program performance. Although this type of measure has often been unusable in the public sector, OIG considered it an important gauge of the monetary value received by American taxpayers in return for investment in the work of OIG. It is a ratio that directly links the cost of operating OIG's HCFAC Program to the financial return resulting from audits, investigations and recoveries.

ROI combines the following desirable attributes. It links budget and performance by revealing the cost-effectiveness of OIG. Also, it promotes teamwork within OIG, with other components of HHS and with other agencies of government, including the DOJ and the states.

The numerator used in arriving at the ROI consists of two elements. The first is expected recoveries, which includes court and administratively assessed fines, penalties, restitution, and forfeitures; and final audit disallowances. The second is savings from funds not expended, which includes savings resulting from OIG-recommended policy changes implemented through legislative, regulatory or administrative action; and redirected funds (also called funds put to better use).

The ROI is arrived at by dividing the expected recoveries and savings from funds not expended, by the category of OIG budget dollars used, and expressing the results as a ratio (e.g., 100:1 or 10:1). This provides a direct linkage between budget and performance. OIG began setting ROI targets in FY 2002.

Performance Measure: Total expected Medicare and Medicaid recoveries and savings per dollar invested (in millions).		
	Target	Actual
FY 2002	$79:1	01/2003
FY 2001	-	$136:1
FY 2000	-	$130:1
FY 1999	-	$125:1

(Source: CIMS database)

In FY 1996, OIG first reported on audit work that documented an alarmingly high rate of improper Medicare payments. Nearly 14 percent of FY 1996 fee-for-service claims payments, amounting to a cost to the taxpayer of more than $23 billion, were estimated to be erroneous.

Since then CMS instituted educational efforts and corrective actions that have significantly reduced the severity of the problem. As a result, follow-up work by OIG has documented a steady decline in payment errors. In FY 2001, the error rate was estimated to be 6.3 percent. This represented approximately $12 billion in improper payments, roughly half of what it was in FY 1996, but still a very large, unnecessary expenditure of funds.

In FY 2002, OIG was committed to continuing to work in partnership with CMS to further reduce the rate of Medicare improper payments and to measure and address similar problems elsewhere in the Department. CMS has set a target for the Medicare payment error rate beginning in FY 2003.

Performance Measure: Reduce the Medicare Payment fee-for-service Error Rate.		
	Target	Actual
FY 2002	5.0%	03/2003
FY 2001	6.0%	6.3%
FY 2000	7.0%	6.8%
FY 1999	9.0%	7.97%

(Source: AIMS database and reports produced by the OIG)

Improving Human Capital

Program Background and Context

The Department's employees "our human capital" are a key to accomplishing our mission and goals. Mission accomplishment requires that we align our human capital with the Department's strategic direction. This requires workforce planning - having the right people with the right skills doing the right jobs at the right time. But it also means knowing what those skills are, how the requirements are changing, and how our workforce is changing, so that we can take the steps to find, recruit, hire, and keep the workforce that we will need.

Program Performance Planning

HHS has assertively moved to align its human capital programs with the Department's mission. These initiatives to improve human capital management are part of our efforts to implement the President's Management Agenda, aimed at making HHS a more citizen-centered Department.

Our efforts include systematically eliminating unnecessary management layers, so that there will be no more than four levels from the front-line worker to the top decision-makers. As part of its restructuring plan, HHS is consolidating its 40 human resources (HR) offices into four departmental HR servicing sites by the end of FY 2003.

The department-level HR consolidation is mirrored by efforts by all the HHS operating divisions to consolidate administrative functions, eliminate duplicative offices, and re-deploy staff to mission functions. These actions are just part of the Department's efforts to align its human capital to its strategic direction.

Workforce planning has pointed up issues of growing retirement eligibility and hot spots in resignations and turnover. HHS' cross-cutting Recruitment and Retention Plan has put in place initiatives to address these issues by recruiting, hiring, and keeping the workforce we will need in the future.

The Department's Recruitment and Retention plan has fostered several departmental human capital initiatives of note, including the Emerging Leaders Program, an innovative career intern

program to develop future leaders; the HHS Corporate University, consolidating common needs training in one place; an exit interview project to analyze why employees leave; and a retention study to develop information on the factors that influence employees to stay with HHS. Taken together, these targeted actions to find, hire, place, develop, and keep employees with critical skills are the cornerstone of aligning HHS's human capital to mission accomplishment.

Means and Strategies

These efforts cut across HHS. As departmental initiatives, they are reflected and supported in the OPDIV plans. The Department's human capital initiatives can be summed up in five cross-cutting efforts:

- Implement departmental recruitment and retention strategies;
- Develop and implement strategic workforce plans to respond to and eliminate skills imbalances;
- Consolidate administrative functions to eliminate duplication and increase efficiency and effectiveness;
- De-layer organizations to no more than four management layers to speed decision-making; and
- Deploy staff to mission-related functions to improve HHS as a citizen-centered Department.

Facilities Improvement
Centers for Disease Control and Prevention (CDC)

The Program

The CDC expanded its workforce and responsibilities considerably since its post-World War II origins. As public health challenges have become more serious and complex, CDC's laboratory- and nonlaboratory-based programs have also expanded to meet changing needs. Because of this growth, CDC-owned buildings were unable to house most of its employees, half of CDC's Atlanta workforce work in 23 leased buildings. Some CDC scientists conduct experiments on infectious micro-organisms in wooden buildings that were constructed as temporary facilities almost 60 years ago.

CDC undertook a facility planning effort to consolidate its Atlanta operations into two secure campuses. The highest priorities in this effort include annual repair and improvements to CDC's nationwide facilities, completion of the emerging Infectious Disease Laboratory and completion of the Environmental Toxicology Laboratory at the Chamblee Campus. CDC's goal is to provide safe, modern, efficient and physically secure laboratories and support facilities in the most economical manner possible.

Results and Explanation of Performance

CDC has implemented the first part of an innovative new contracting structure to speed the procurement of major capital projects. CDC used a highly competitive process to "pre-qualify" architecture and construction firms to form a pool of resources readily available for use on a task order basis for design and construction. To date, CDC has successfully procured design services for several major construction projects in approximately one-third to one-quarter of the time normally needed for traditional procurements. Another feature of the contract was to bring the architect and building together from inception of a project rather than after the design is complete. This feature ensured a better final product, reduced order changes and allowed better adherence to budget and schedule.

In FY 1998, CDC began its planning state for construction of Building 109 (Infectious Disease Laboratory). In FY 1999 and FY 2000, consistent with available resources, design and construction continued on schedule. In FY 2001, construction at the Chamblee campus was completed. In FY 2002, occupancy and phase II is continuing on schedule.

Performance Measure: Complete construction of infectious disease laboratory, Building 109, to replace Buildings 4, 6, 7, 8 and 9 Chamblee campus.		
	Target	Actual
FY 2002	Completed construction	On schedule.
FY 2001	Complete construction	Complete - Occupancy estimated for 1/2002.
FY 2000	Begin construction.	Acquisition of construction contract underway; task order award anticipated in 2000.
FY 1999	-	Design underway; expected to be completed on schedule/within budget.
FY 1998	-	Planning stage

(Source: CDC FY 2002 Annual Performance Report - pg. 178)

In FY 1998, CDC began its planning stage for the design and construction of building 110 (Environmental Toxicology Laboratory). During FY's 1999, 2000 and 2001, planning efforts continued and, in FY 2002, contractors completed the design and began construction. CDC's target for completion of this construction is FY 2004.

Performance Measure: Design and construct an Environmental Toxicology Laboratory, Building 110, to replace Buildings 17, 25, 31 and 32, Chamblee campus.		
	Target	Actual
FY 2002	Complete design; begin construction.	Begin construction.
FY 2001	Begin design.	On schedule.
FY 2000	-	-
FY 1998	-	Planning stage.

(Source: CDC FY 2002 Annual Performance Report - pg. 179)

As of June 2002, implementation of approved projects was proceeding according to schedule. CDC continues to monitor projects currently entering the design and construction cycle to obtain quantitative data on performance objects.

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

The Program

The Substance Abuse Prevention and Treatment Block Grant (SAPTBG) continues to support states in ensuring that thousands of Americans with substance abuse problems have access to the best treatment services possible, when and where they need them. The SAPTBG accounts for approximately 50 percent of all public funds expended by the states for substance abuse treatment and prevention. This program also represents a major portion of SAMHSA's contribution to closing the treatment gap, which is a national treatment plan goal shared among SAMHSA, the Office of National Drug Control Policy, and many partners. Research continues to show that drug treatment is effective in reducing drug use and the consequences of addiction.

According to most recent trend data from the Treatment Episode Data Set (TEDS) Report, (2000), the Substance Abuse Block Grant program has supported approximately 1.6 million admissions for substance abuse treatment per year since 1993 and provided annual funding to over 7,000 substance abuse treatment providers. In addition, a five percent set-aside is used to support Block Grant activities for improving treatment by funding needed technical assistance, data collection, and evaluation activities.

The Substance Abuse Block Grant program has supported approximately 1.6 million admissions for substance abuse treatment per year since 1993.

Results and Explanation of Performance

Performance Measure: Number of Clients served.		
	Target	Actual
FY 2002	1,751,537	09/2004
FY 2001	1,635,422	09/2003
FY 2000	1,525,688	09/2002
FY 1999	-	1,587,510 estimate

(Source: Treatment Episode Data Set [TEDS] Report 2000)

Estimates from the TEDS has indicated that 1,587,510 persons were served through the SAPTBG in FY 1999. SAMHSA projects serving 1,525,688 persons in FY 2000, with increases in future fiscal years to reflect funding increases designed to reduce the treatment gap.

TEDS data represent admissions to treatment, not unique persons served during the year. The majority of states should be able to report unduplicated client counts by the end of FY 2002. Some states, however, will be unable to report this information due to laws prohibiting the use of unique client identifiers and data system limitations.

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